Oregon Solutions Declaration of Cooperation

Lane County Physician Assistant and Nurse Practitioner

December 10, 2015

I. Project Snapshot

Primary care is critical to improve population health. Physicians, physician assistants and nurse practitioners can provide primary care.

There is a documented shortage of physician assistants (PA) and nurse practitioners (NP) in Lane County. The report titled Projected Demand for Physicians, Nurse Practitioners, and Physician Assistants in Oregon: 2013-2020 by the Oregon Health Authority (revised Feb. 2014), says that in 2020 there will be a provider **shortage of PAs (6-22)** and **shortage of NPs (20-49)** in Lane County. These numbers do not include retirements, any reduction in practice hours and relocations out of the community. These numbers are not exclusive to primary care, they are PAs and NPs engaged in any type of practice.

Governor Kate Brown designated this effort an Oregon Solutions project in a May 21, 2015 letter. (see Appendix A) Governor Brown appointed Juine Chada (US Senator Wyden's Office) and Debi Farr (Trillium Community Health Plans Public Affairs Director) as co-conveners to lead a team of primary care providers, health care organizations and higher education organizations to create a plan to increase the number of PAs and NPs delivering primary healthcare services in Lane County. The Oregon Solutions (OS) project team participants represent a cross-section of the community. They are listed in Appendix B.

Project team members learned that it is critical to recognize that, in some respects, PAs and NPs are significantly different in their training, philosophy and professional practice with patients. Descriptions of Oregon Nurse Practitioners and Physician Assistant are in Appendix C and D.

The project team initially identified three key areas to focus their efforts: increasing clinical rotation/practicum capacity, locally enhancing student incentives, and exploring whether local didactic classroom capacity was needed in Lane County. During the process a preceptor tax credit was identified as another critical long term solution.

The Community Action Plan (see Attachment A) is what the project team thinks needs to be done to solve the problem. The Declaration of Cooperation is a list of commitments designed to successfully implement the plan.

II. Oregon Solutions Process Description

Oregon Solutions (OS) is a program of the National Policy Consensus Center at Portland State University. The mission of Oregon Solutions is to develop solutions to community based problems that support sustainable objectives for the economy, the community and the environment and are built through the collaborative efforts of citizens, businesses, government and non-profit organizations. The OS approach integrates and makes efficient use of public and private investments, elevates the visibility of the project

and engages communities in creating solutions. The process provides a neutral forum - a place where various interests and stakeholders can come together as parties in a "Project Team," in a manner that is more neutral than a meeting sponsored or hosted by one of the parties at the table.

Through the Oregon Solutions process, collaboration among parties on the Project Team increased and evolved during the process. The intent was to foster and facilitate agreements amongst the parties about which potential actions, or suite of potential actions, may be taken to cumulatively lead to successful project outcomes, including identifying who may be appropriate to take specific actions, how and when. This collaborative work product is documented at the end of the OS process in the Declaration of Cooperation (DoC). The DoC, including the stakeholder commitments, is considered to be a "living" document that may evolve with the opportunities for parties to amend by unanimous consent from time to time, to represent changing situations often found during project development, until project completion or until suspended by mutual agreement.

Oregon Solutions staff member Jim Jacks served as facilitator and project manager.

III. Project Background and Project Team Activities

Background

This project grew out of a series of community conversations among local stakeholders concerned about the need to increase access to primary care and the limitations associated with the existing shortage of physician assistants and nurse practitioners in Lane County. There is a general shortage of physician assistants and nurse practitioners across Oregon and the United States. The shortage is driven by a variety of reforms, industry trends and demographic trends.

According to the Oregon Health Authority (OHA) in 2012 Oregon had approximately 10,500 FTEs of medical doctors, 2,000 FTEs of nurse practitioners, and 1,000 FTEs of physician assistants. In 2012 Lane County had approximately 900 FTEs of medical doctors, 150 FTEs of nurse practitioners, and 75 FTEs of physician assistants.

The Oregon Health Authority projects that in 2020 there will be a provider shortage of 6-22 PAs and a shortage of 20-49 NPs in Lane County. However, these numbers do not include any retirements, any reduction in practice hours and any relocations out of the community. Because of this, the project team assumes the community will need more providers than the 6-22 PAs and 20-49 NPs ranges calculated by OHA. These PA and NP numbers are not exclusive to primary care, they are PAs and NPs engaged in any type of practice.

Current PA and NP Educational Capacity

Given the national shortage many states and communities are attempting to increase the supply of PA and NP healthcare providers.

According to the national Physician Assistant Education Association (PA EA) there are currently 221 PA programs in the US. This includes 38 provisional programs and 26 programs that are developing but not yet accredited. However, in Oregon the only two PA programs are at Oregon Health and Science University (OHSU) and Pacific University. These are well established and successful programs each graduating between 40-55 PAs per year.

According to the American Association of Colleges of Nursing (AACN) in the fall of 2013 there were more than 400 nurse practitioner education programs in the US. However, in Oregon the only two NP

programs are at Oregon Health and Science University (OHSU) and the University of Portland. Each year OHSU has 16-22 students who graduate with a Masters of Nursing in the Family Nurse Practitioner program. Of those between 40%-80% will continue to complete the Doctor of Nurse Practitioner (DNP) degree which is another year of study.

The existing PA and NP programs in Oregon receive hundreds and hundreds more applications from qualified prospective students than there are available classroom positions. The project team discussed the topic of expanding didactic capacity in Lane County.

However, the bottleneck in the PA and NP educational pipeline is the clinical rotation/practicum part of a student's educational experience. The issue is a lack of preceptors in communities to teach students in clinics, medical centers and other provider settings. The project team recognizes that increasing the number of preceptors must be done before expanding didactic capacity in Oregon.

Project Team Activities

The Oregon Solutions (OS) project team was charged to create a plan to increase the number of PAs and NPs delivering primary healthcare services in Lane County. The project team had monthly two hour meetings on June 11th, July 29th, August 19th, September 29th and October 20th. Workgroup and Subcommittee meetings occurred on August 11th, September 9th and October 27th.

During the OS process several Workgroups were formed: Clinical Rotations Workgroup, Student Incentives Workgroup, and the Preceptor Tax Credit Subcommittee. These groups were critical to the success of the OS project team. The two Workgroups were tasked by the project team to provide specific recommendations to consider moving forward with. The project team winnowed the lists and the resulting options were then more fully explored.

Clinical Rotations Workgroup

The bottleneck in the PA and NP educational pipeline is the clinical rotation/practicum part of a student's educational experience. The limiting factor is the lack of current medical doctors, physician assistants and nurse practitioners who are both willing and able to serve as preceptors for students. This bottleneck was apparent from the first meeting and the preceptor topic was the dominant issue throughout the project team's five meetings. The project team believes that increasing the number of preceptors in Lane County will lead to several benefits.

From an employer point of view, having a PA student for a full time 4-6 week rotation or an NP student for a practicum of 40-160 hours over a ten week term, can function as an extended job interview. Many provider organizations pay professional recruiting firms to help them hire MDs, PAs, and NPs. Between the recruiter fee, interviewee travel costs, signing bonus and moving expenses etc. it can easily cost an employer $80,000 or more to recruit and hire a new staff member. A clinic could choose to invest in staff time precepting students and hire the ones they like in order to avoid a much more expensive hiring process.

From a student point of view, they get an experience with a clinic, medical center or other care provider. They might like it enough that they decide they want to work there after graduation. They also have a chance to get acquainted with a community. If students from out of state do a clinical rotation or practicum in Lane County they may discover how attractive a place it is to live in and decide to relocate after graduation.

The Clinical Rotations Workgroup explored the many obstacles professionals experience when deciding to precept students. The Community Action Plan and the commitments in this Declaration of Cooperation will address many of the identified obstacles.

Student Incentives Workgroup

PA and NP students can experience a variety of obstacles during their educational experience. The Workgroup explored these and then potential solutions. The project team is moving forward in three main areas: scholarships/tuition reimbursement, housing, and creating separate groups or cohorts of Lane County PA students and NP students. These are detailed in the Community Action Plan and the commitments in the Declaration of Cooperation.

Preceptor Tax Credit Subcommittee

The Preceptor Tax Credit Subcommittee met to learn about the State of Georgia's tax incentive that passed in 2014. The Subcommittee made significant changes through an iterative process. The resulting one page document (see Appendix G) contains six main points and is broadly agreed to by project team members. They recognize that the legislative process will likely result in changes.

The Community Action Plan contains the results from the Workgroups, the Subcommittee and project team as a whole. Workgroups were a focal point of the project team's collaborative energy during the Oregon Solutions process.

IV. Community Action Plan

The project team worked hard and learned a lot about the problems and obstacles associated with increasing the number of PAs and NPs working in primary care in Lane County.

What is the Community Action Plan?

The Community Action Plan is what the project team thinks needs to be done to solve the problem. The Declaration of Cooperation is a list of commitments designed to successfully implement the plan.

The Plan contains a variety of short term, medium term and long term actions and activities. These are arranged in three main areas. Many of the short term items are already complete. Several of the appendices to the Declaration of Cooperation contain information collected by project team members and/or OS staff.

Structure Moving Forward

In order to successfully implement this plan, there will be three Committees: Clinical Rotations/Practicum Committee, Student Incentives Committee and the PA-NP Recruiting Committee. They will meet at least monthly from January until June 30, 2016. They will be the focal point of the group's energy moving forward. Not everyone will serve on each committee. Some of the appendices contain information specifically for Committee use.

V. Commitments

The goals and aspirations represented in the following pages form a public statement of intent to participate in the project, to strive to identify opportunities and solutions whenever possible, to contribute assistance and support within resource limits, and to collaborate with other team members in increasing the number of PAs and NPs providing primary care in Lane County. Team members acknowledge that the best solutions depend upon the cooperation by all entities at the table. Accordingly, they recognize that each party has a unique perspective and contribution to make and legitimate interests that need to be taken into account for the project's success.

The Oregon Solutions process and the Declaration of Cooperation represent the goals and aspirations of the stakeholders which participated in the Oregon Solutions process. These goals and aspirations are necessary to: maintain the involvement of the project stakeholders, provide a mechanism for each stakeholder to continue to actively participate and serve as a roadmap to guide us towards successful implementation of this community action plan.

Oregon Solutions

Oregon Solutions was tasked by Governor Kate Brown to assist the co-conveners in managing this project team and providing a neutral forum in which team members could work productively toward creating a community action plan.

Oregon Solutions commits to the following:

- Endorses the community action plan as described in Attachment A.
- Highlight this project team on the Oregon Solutions website and other promotional materials.
- Take the lead in re-convening the project team within the first year anniversary of the signing of this Declaration.
- Co-convener Debi Farr agrees to lead the Oregon Solutions re- convening meeting in about one year.
- Co-convener Juine Chada agrees to lead the Oregon Solutions re- convening meeting in about one year.

Debi Farr
Oregon Solutions, Co-convener

Juine Chada
Oregon Solutions, Co-convener

Statement of Commitment

This Declaration of Cooperation, while not a binding legal contract, is evidence to, and a statement of, the good faith and commitment of the undersigned parties. The undersigned parties to this Declaration of Cooperation have, through a collaborative process, agreed and pledged their cooperation to the following actions:

Governor Kate Brown's Office

Governor Kate Brown's Office commits to the following:

- Provide opportunities to share this project team's work with the Regional Solutions Advisory Committee and appropriate Governor's Office staff.
- Serve on the PA-NP Recruitment Committee until June 30, 2016.
- Participate in "scholarship/tuition reimbursement" discussions conducted by the Student Incentives Committee.
- Participate in the Oregon Solutions reconvening meeting in about one year.

Jackie Mikalonis 12/10/2015

Jackie Mikalonis Date

Governor Kate Brown's Office, Regional Solutions Coordinator

Statement of Commitment

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Lane Community College

Lane Community College commits to the following:

- Endorses the community action plan as described in Attachment A and supports its implementation.
- Identify and encourage LCC students to consider becoming PAs or NPs.
- Serve on the Student Incentives Committee until June 30, 2016.
- Support legislative adoption of a preceptor tax credit.
- LCC is open to exploring with other higher education organizations how we can locally assist PA and NP students.
- Participate in the Oregon Solutions reconvening meeting in about one year.

Mary E T Spilde 12·10·15

Mary Spilde Date
Lane Community College, President

Statement of Commitment

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Lane County Health and Human Services

Lane County Health and Human Services commits to the following:

- Endorses the community action plan as described in Attachment A and supports its implementation.
- Serve on the Clinical Rotation/Practicum Committee until June 30, 2016.
- Identify and thank all medical staff currently involved in precepting students.
- Create a list of current and/or potential preceptors and arrange colleague to colleague invitations to precept.
- Support legislative adoption of a preceptor tax credit.
- Regularly encourage current RNs to consider becoming NPs.
- Participate in the Oregon Solutions reconvening meeting in about one year.

Alicia Hays 12/8/15

Alicia Hays Date
Lane County Health and Human Services

Statement of Commitment

This Declaration of Cooperation, while not a binding legal contract, is evidence to, and a statement of, the good faith and commitment of the undersigned parties. The undersigned parties to this Declaration of Cooperation have, through a collaborative process, agreed and pledged their cooperation to the following actions:

Lane County Medical Society

LCMS commits to the following:

- Endorses the community action plan as described in Attachment A and supports its implementation.
- Serve on the Clinical Rotations/Practicum Committee until June 30, 2016
- Serve on the PA & NP Recruiting Committee until June 30, 2016.
- Help identify and thank all medical doctors currently involved in precepting students.
- Help create a list of current and/or potential preceptors and arrange colleague to colleague invitations to precept.
- Support legislative adoption of a preceptor tax credit.
- Use the newsletter and events to highlight preceptors and attract new ones
- Help create a coordinated community recruitment program.
- If the project team funds a staff person to help implement the Community Action Plan or to act as a Preceptor Coordinator, LCMS is open to being considered to act as fiscal agent or offer office space.
- Participate in the Oregon Solutions reconvening meeting in about one year.

Candice J. Barr 2-3-2016

Candice Barr — Date
Lane County Medical Society, CEO

Statement of Commitment

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Lane County Nurse Practitioners Association

This project/effort is important to the LCNPA for the following reasons:

- According to the Oregon Health Authority, it is projected that in 2020 there will be provider shortages of 20 – 49 NP's and 6 – 22 PA's in Lane County. These numbers do not include retirements, reduction in practice hours or relocations out of the community.
- The LCNPA Board of Directors is able to facilitate the gathering of data needed to quantify the projected need for Nurse Practitioners in Lane County through their e-mail distribution list.
- The LCNPA Board of Directors is committed to promoting education opportunities for NP's within Lane County.
- Through regular meetings, education oriented dinners, our annual educational conference, and other activities; the LCNPA Board of Directors promotes fellowship, camaraderie and professional support amongst NP's within our community.
- We recognize the need for more Clinical Preceptors for NP students in Lane County and routinely post preceptor needs through our email distribution list.
- Through our email distribution list, we are able to facilitate ongoing communication specific to recruitment and retention of NPs to our community.

Lane County Nurse Practitioners Association commits to the following in efforts to increase the numbers of NP's in Lane County:

- Regular attendance by an LCNPA Board Member, or their designee, at Oregon Solutions Network NP-PA Workgroup meetings.
- Regular communication and planning (during the months of June – September) by an LCNPA Board Member, or their designee, with the OS project team coordinator, or their designee, in regards to OS NP/PA workgroup topics.
- LCNPA will share a link to an online Lane County Nurse Practitioner Survey, created and tallied by Oregon Solutions Network staff, to members of the LCNPA email distribution list.
    - To encourage participation in the above NP survey, LCNPA will provide an incentive – an "iPad air 2", to one, randomly selected survey participant.
    - Oregon Solutions will supply all results of the above survey to the LCNPA Board.
- LCNPA will send NP preceptor recruitment requests and NP position openings to members of our email distribution list.
- LCNPA will send e-mail queries to members of our email distribution list to identify NP's in Lane County who are willing to provide short-term housing for NP students doing clinical rotations here in Lane County.
- LCNPA will present a short synopsis of the NP/PA Workgroup Actions at our annual Education Conference in February 2016, and will recruit preceptors for NP students at this time.

Diana Lamboy NP 2-2-201

Diana Lamboy NP Date

Lane County Nurse Practitioners Association, Board President

Statement of Commitment

This Declaration of Cooperation, while not a binding legal contract, is evidence to, and a statement of, the good faith and commitment of the undersigned parties. The undersigned parties to this Declaration of Cooperation have, through a collaborative process, agreed and pledged their cooperation to the following actions:

Linn Benton Community College

Linn-Benton Community College commits to the following:

- Endorses the community action plan as described in Attachment A and supports its implementation.
- Identify and encourage LBCC students to consider becoming PAs or NPs.
- Support legislative adoption of a preceptor tax credit.
- Participate in the Oregon Solutions reconvening meeting in about one year.

12/15/2015

Dave Henderson — Date

Linn Benton Community College, Vice-President Finance and Operations

Division of Health Policy and Analytics

Kate Brown, Governor

Oregon Health Authority

500 Summer Street, NE
Salem, OR 97301

Statement of Commitment

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Oregon Health Authority
The Oregon Health Authority recognizes the need to increase access to primary care in Lane County and throughout Oregon. OHA contracted with Oregon Solutions to provide facilitation and project management services for this project team. Successfully addressing the clinical rotation/practicum bottle neck experienced by Physician's Assistant and Nurse Practitioner students will require increasing the number of preceptors in Lane County and statewide.

Oregon Health Authority commits to the following:

- Endorses the community action plan as described in Attachment A and supports its implementation.
- Continue collecting, analyzing and distributing health professions data for Oregon and Lane County.
- Highlight the work of this project team and the importance of medical professionals serving as preceptors.
- Participate in the Oregon Solutions reconvening meeting in 2016.

Marc Overbeck
Oregon Health Authority, Primary Care Office Director

Dec. 16, 2015
Date

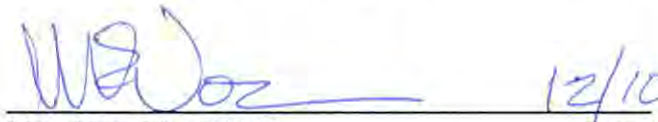
Statement of Commitment

This Declaration of Cooperation, while not a binding legal contract, is evidence to, and a statement of, the good faith and commitment of the undersigned parties. The undersigned parties to this Declaration of Cooperation have, through a collaborative process, agreed and pledged their cooperation to the following actions:

Pacific University

Pacific University commits to the following:

- Endorses the community action plan as described in Attachment A and supports its implementation.
- Identify and encourage Pacific University undergraduate students to consider becoming PAs or NPs.
- Serve on the Clinical Rotation/Practicum Committee until June 30, 2016
- Serve on the Student Incentives Committee until June 30, 2016.
- Consider providing, in collaboration with OHSU, an admissions advantage to (1-2) qualified applicants from Lane County for PA classes starting in the years 2017-2022. (Contingent upon local clinical rotation placement availability)
- Support legislative adoption of a preceptor tax credit.
- Consider funding (with other project team partners) a part time Project Manager who would work 5-10 hours per week through June 30, 2016 to help the project team implement the community action plan.
- Consider funding (with other project team partners) a Preceptor Coordinator. This position would work with local health providers and higher education PA and NP programs to recruit preceptors in Lane County and coordinate the clinical rotations/practicums for PA and NP students.
- Participate in the Oregon Solutions reconvening meeting in about one year.



12/10/2015

Mary Von, PA-C, DHEd — Date

Pacific University, Physician Assistant Program Director

Statement of Commitment

This Declaration of Cooperation, while not a binding legal contract, is evidence to, and a statement of, the good faith and commitment of the undersigned parties. The undersigned parties to this Declaration of Cooperation have, through a collaborative process, agreed and pledged their cooperation to the following actions:

PeaceHealth – Sacred Heart Medical Center

PeaceHealth – Sacred Heart Medical Center commits to the following:

- Endorses the community action plan as described in Attachment A and supports its implementation.
- Serve on the Clinical Rotation/Practicum Committee until June 30, 2016.
- Identify and thank all medical staff currently involved in precepting students.
- Create a list of current and/or potential preceptors and arrange colleague to colleague invitations to precept.
- Consider funding (with other project team partners) a part time Project Manager who would work 5-10 hours per week through June 30, 2016 to help the project team implement the community action plan.
- Consider funding (with other project team partners) a Preceptor Coordinator. This position would work with local health providers and higher education PA and NP programs to recruit preceptors in Lane County and coordinate the clinical rotations/practicums for PA and NP students.
- Support legislative adoption of a preceptor tax credit.
- Regularly encourage current RNs to consider becoming NPs.
- Participate in the Oregon Solutions reconvening meeting in about one year.

Wendy Apland Date
PeaceHealth – Sacred Heart Medical Center, Chief Financial Officer

Rick Yecny, Chief Administrative Officer, Florence Peace Harbor Hospital and Cottage Grove Community Hospital
Tim Herrmann, VP Patient Care Services, Cottage Grove Community Hospital
Julie Hughes, MD, VP Medical Affairs, Sacred Heart Medical Center
Rick Kincade, MD, Medical Director, PeaceHealth Medical Group Systems of Care
Gary Halvorson, MD, Medical Director, Center for Medical Education & Research
Chris Traver, Director, Center for Medical Education & Research

Statement of Commitment

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Trillium Community Health Plans

Trillium Community Health Plans commits to the following:

- Endorses the community action plan as described in Attachment A and supports its implementation.
- Serve on the Clinical Rotation/Practicum Committee until June 30, 2016.
- Serve on the Student Incentives Committee until June 30, 2016.
- Serve on the PA & NP Recruiting Committee until June 30, 2016.
- Act as a facilitator to arrange preceptor agreements with providers.
- Consider funding (with other project team partners) a part time Project Manager who would work 5-10 hours per week through June 30, 2016 to help the project team implement the community action plan.
- Consider funding (with other project team partners) a Preceptor Coordinator. This position would work with local health providers and higher education PA and NP programs to recruit preceptors in Lane County and coordinate the clinical rotations/practicums for PA and NP students.
- Support legislative adoption of a preceptor tax credit.
- Participate in the Oregon Solutions reconvening meeting in about one year.

Terry Coplin — Date

Trillium Community Health Plans, CEO

Statement of Commitment

This Declaration of Cooperation, while not a binding legal contract, is evidence to, and a statement of, the good faith and commitment of the undersigned parties. The undersigned parties to this Declaration of Cooperation have, through a collaborative process, agreed and pledged their cooperation to the following actions:

Willamette Valley Cancer Institute

Willamette Valley Cancer Institute commits to the following:

- Endorses the community action plan as described in Attachment A and supports its implementation.
- Serve on the Clinical Rotations Committee until June 30, 2016
- Identify and thank all medical staff currently involved in precepting students.
- Work to maintain or increase the number of local clinical rotations WVCI currently provides.
- Create a list of current and/or potential preceptors and arrange colleague to colleague invitations to precept.
- Support legislative adoption of a preceptor tax credit.
- Participate in "post graduation training" discussions conducted by the PA-NP Recruitment Committee.
- Participate in the Oregon Solutions reconvening meeting in about one year.

Ben Cho, MD
Willamette Valley Cancer Institute, Immediate Past Practice President
Oregon Society of Medical Oncology, President

RON WYDEN
OREGON

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COMMITTEES:
COMMITTEE ON THE BUDGET
COMMITTEE ON ENERGY AND NATURAL RESOURCES
SUBCOMMITTEE ON PUBLIC LANDS AND FORESTS
SPECIAL COMMITTEE ON AGING
SELECT COMMITTEE ON INTELLIGENCE
COMMITTEE ON FINANCE

December 10, 2015

Lane PA-NP Project Team
c/o Jim Jacks, Project Manager

Dear Lane PA-NP Project Team:

I am writing to express my congratulations to the Lane Physicians Assistant-Nurse Practitioner (PA-NP) Project Team for the recent signing of an Oregon Solutions Memorandum of Understanding of a Declaration of Cooperation (DoC) The DoC is the culmination of five months of extraordinary effort by many partners on the common goal of increasing the number of physician's assistants and nurse practitioners in Lane County.

I was pleased that Governor Brown had designated the Lane PA-NP as an Oregon Solutions project. There is a troubling shortage of primary care physicians, physician assistants and nurse practitioners which has been documented in a variety of reports by the Oregon Health Authority. This shortage has left many without reliable access to primary medical care services. You have been doing great work along with health care organizations, primary care providers and educators to develop a solution to this problem. My staff has apprised me of the successful collaborative work to identify three key areas of focus aimed at increasing the numbers of physician assistants and nurse practitioners being trained and working in Lane County.

You should be proud of the relationships you have built and the creative solutions you have developed. You clearly understand that the best solutions depend upon cooperation by all entities at the table. Successful implementation of your action plan will require ongoing collaboration and connection among non-profit, private and public organizations working in Lane County.

I have asked my staff to remain engaged in your efforts and work closely with you to help the Lane PA-NP team move forward. Please feel free to contact my office if we can be of any assistance.

Sincerely,

Ron Wyden

RON WYDEN
United States Senator

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ROOM 118
MEDFORD, OR 97501
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THE JAMISON BUILDING
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707 13TH ST, SE
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VI. Attachment & Appendices

Attachments

Attachment A	Community Action Plan

Appendices

Appendix A	Governor Kate Brown's Designation letter
Appendix B	Project Team Participants
Appendix C	Oregon Defined Nurse Practitioner Description
Appendix D	Oregon Defined Physician Assistant Description
Appendix E	Oregon and National Salary Trends for Nurse Practitioners
Appendix F	Oregon and National Salary Trends for Physician Assistants
Appendix G	Preceptor Tax Credit Recommendation
Appendix H	List of state and federal student loan programs and financial aid programs
Appendix I	List (partial) of Primary Care Providers in Lane County
Appendix J	List of current clinical rotation and practicum hours needed
Appendix K	Current (Aug 2015) & Future Student Placements
Appendix L	Preceptor Kit (job description, application, CME credit, tips, etc.)

1 Preceptor Duties & Responsibilities (PHMG)
2 Clinical Physician Faculty Roles & Responsibilities (PHMG)
3 Preceptor Application Form (Western University of Health Sciences)
4 PA and NP Preceptor Requirements & Opportunities to Receive CME Credit
5 Tips for the Teaching Physician (PHMG)
6 What Can We Learn from our Successful Clinical Preceptors?
(PAEA presentation 4 pages)
7 Mastering the Preceptor Role: Challenges of Clinical Teaching
(NAPNP article 11 pages)
8 Preceptor Toolkit (AANP 34 page powerpoint)
9 Supervising, teaching and Evaluating Fourth Year Medical Students
(OHSU 33 slide powerpoint on 6 pages)

Attachment A **Community Action Plan** **Declaration of Cooperation 12/15/2015** **OS-Lane PA-NP Project Team**

	Topic	What To Do	Who	By When Short Term (2-29-16)	Medium Term (4-30-16)	Long Term (9-30-16)
1.0	**Clinical Rotations / Practicum Committee**					
1.1	Preceptor Job Description	Provide job description	Chris Traver, Di Lacey, Mary Von, Jim Jacks (DoC appendix)	Completed		
1.2	Preceptor Training Information	Provide training info	Chris Traver, Di Lacey, Mary Von, Jim Jacks (DoC appendix)	Completed		
1.3	Preceptor CME		Chris Traver, Jim Jacks	Completed		
1.3.A.1		Collect info OSBN gives CME for NP preceptors	Jim Jacks and others	Completed		
1.3.A.2		Collect info OR Medical Board MD & PA preceptors	Jim Jacks and others	Completed		
1.3.B		Distribute	Jim Jacks (DoC appendix)	1/31/2016		
1.4	Lane County Medical Society	Newsletter articles promoting preceptors.	Gary Halvorson writes it. Candice Barr publishes it.	Completed	March Newsletter	June Newsletter
1.4.A		Increase preceptor visbility at LCMS meetings/events	Candice Barr & LCMS board	Ongoing	Ongoing	Ongoing
1.4.B		Recruitment table at LCMS events	Chris Traver and others	Ongoing	Ongoing	Ongoing
1.5	Lane County Nurse Practitioner Association Survey	Conducts survey & shares results	Lane County Nurse Practitioner Association Board	2/19/2016		
1.6	OWHI Report	Distributes report to project team	Oregon Healthcare Workforce Institute	12/18/2015		
1.7	Thank existing preceptors	Specific individualized thank you to existing preceptors	LCMS, LCNPA, LCHHS, McK-Will, OHSU NP, OHSU PA, Pacific U, PH Sacred Heart, PH Cottage Grove, PH Florence, Trillium, WVCI	2/29/2016		
1.7.A		OHSU Library access for preceptors	Chris Traver & OHSU have been working on this. On track to finish.		4/30/2016	

	Topic	What To Do	Who	By When Short Term (2-29-16)	Medium Term (4-30-16)	Long Term (9-30-16)
1.8	Recruit Preceptors					
1.8.A		Create list potential MD, PA, NP preceptors	LCMS, LCNPA, LCHHS, McK-Will, OHSU NP, OHSU PA, Pacific U, PH Sacred Heart, PH Cottage Grove, PH Florence, Trillium, WVCI	2/29/2016		
1.8.B		Colleague to colleague "ask" MDs, PAs, NPs to be preceptors.	LCMS, LCNPA, LCHHS, McK-Will, OHSU NP, OHSU PA, Pacific U, PH Sacred Heart, PH Cottage Grove, PH Florence, Trillium, WVCI	2/29/2016	Ongoing	Ongoing
1.8.C		Ask your PCP be a preceptor	Everyone	Ongoing	Ongoing	Ongoing
1.8.D		Ask current NPs via LCNPA email distribution list	Barbara Johnson & LCNPA board	2/29/2016	Ongoing	Ongoing
1.8.E		Ask current MDs via LCMS channels	Candice Barr & LCMS board	2/29/2016	Ongoing	Ongoing
1.9	Preceptor Coordinator Position	Explore shared position	McKenzie-Willamette, OHA, OHSU PA, OHSU NP, Pacific U, PH Sacred Heart, Trillium, other providers?	Decide yes/no	Hire	Ongoing
1.10	Preceptor Tax Credit					
1.10.A		Analyse Georgia law & decide do something similar or not	Preceptor Tax Credit Subcommittee	Completed		
1.10.B		Study cost of precepting in a variety of settings	Preceptor Tax Credit Subcommittee		3/31/2016	
1.10.C		Work w/legislators to prepare & support legislation, fold into HB 3396 analysis.	Everyone	Ongoing	2016 Legislative Session	Interim Committee Work
1.11	Study NP & PA employment opportunities in Lane County	Ask Kris Kitz (PeaceHealth), Merrit Hawkins recruitment firm, ECG consulting firm for help	Chris Traver	1/31/2016		Annual Review
1.12	How many clinical rotations are needed?	Gather data from OHSU & Pacific U	Jim Jacks (DoC appendix)	Completed		

	Topic	What To Do	Who	By When Short Term (2-29-16)	Medium Term (4-30-16)	Long Term (9-30-16)
2.0	**Student Incentives Committee**					
2.1	Scholarships/Tuition Reimbursement					
2.1.A		Calculate how much is needed	Student Incentives Committee	2/29/2016		
2.1.B		1st draft criteria	Student Incentives Committee	2/29/2016		
2.1.C		Decide criteria	Student Incentives Committee		3/31/2016	
2.1.D		List of possible donors	Student Incentives Committee	2/29/2016	3/31/2016	
2.1.E		Look for foundation grants	Student Incentives Committee	Ongoing	Ongoing	Ongoing
2.1.F		Ask Donors	Jackie Mikalonis, Juine Chada & Student Incentives Committee		3/31/2016	9/30/2016
2.1.G		Distribute money	Student Incentives Committee			9/30/2016
2.2	Housing Program					
2.2.A		Identify participating landlords	OHSU, Pacific U, PeaceHealth	2/29/2016		
2.2.B		Identify list of possible landlords and volunteer hosts (people willing to have students in their homes)	OHSU, Pacific U, PeaceHealth	2/29/2016		
2.2.C		How many units needed and when	Student Incentives Committee	2/29/2016		
2.2.D		Ask landlords/hosts to participate	Student Incentives Committee		3/31/2016	9/30/2016
2.2.E		Decide if a coordinator is needed	Student Incentives Committee	2/29/2016		

	Topic	What To Do	Who	By When Short Term (2-29-16)	Medium Term (4-30-16)	Long Term (9-30-16)
2.3	Lane County PA Cohort of Students					
2.3.A		Pacific U & OHSU both have Sept 1st deadline for following May/June class start				
2.3.B		Agree on # of seats in each school for qualified Lane County applicants	Student Incentives Committee	2/29/2016		
2.3.C		Identify potential students	Lane CC, Linn-Benton CC, UO	Ongoing	Ongoing	Ongoing
2.3.D		Students apply	OHSU, Pacific University			9-1-16 deadline
2.3.E		Successful applicants are organized into Lane cohort	Student Incentives Committee			9/30/2016
2.3.F		Begin classes	OHSU, Pacific University			May/June 2017**
2.4	Lane County NP Cohort of Students					
2.4.A		OHSU mid Dec deadline for fall 2016 start				
2.4.B		Agree on # of seats in each school for qualified Lane County applicants	Student Incentives Committee	2/29/2016		
2.4.C		Identify potential students	Lane CC, Linn-Benton CC, UO	Ongoing	Ongoing	Ongoing
2.4.D		Students apply	OHSU			9/30/2016
2.4.E		Successful applicants are organized into Lane cohort	Student Incentives Committee			9/30/2016
2.3.F		Begin classes	OHSU			9/30/2016

	Topic	What To Do	Who	By When Short Term (2-29-16)	Medium Term (4-30-16)	Long Term (9-30-16)
3.0	**PA & NP Recruiting Committee**					
3.1	Develop post graduation training	Explore models on PA post-grad training process	Chris Traver, Ben Cho, Gary Halvorson	2/29/2016		
3.2	Coordinated community recruitment program	Targeted recruitment of PA/NP students (pre-graduation)	Candice Barr, Ben Cho		4/30/2016	
3.3	Identify salary gaps in Lane County	Collect data from AAPA & NPO	Oregon Solutions	Completed		
3.3.A		Review salary ranges & develop plan to align w/competitive salary	PA & NP Recruiting Committee	2/29/2016		
3.4	Establish Advanced Practice (NP & PA) Society	Targeted CME, PAs dinner	Chris Traver, Gary Halvorson		4/30/2016	
3.5	Explore a "Primary Care" Sector Strategy	Talk to Workforce investment Board (WIB) in Lane County	PA & NP Recruiting Committee	2/29/2016		
3.5.A		Review community aspects to enhance recruitment	PA & NP Recruiting Committee		4/30/2016	
3.6	Professional education of PAs, NPs, MDs	Teach practice sites on professional culture and collaborative practice.	PA & NP Recruiting Committee		4/30/2016	Ongoing
3.7	List of primary care providers in Lane County	Qualtrex survey. Potential projected job openings.	Jim Jacks, State of Oregon Workforce (DoC appendix)	Completed		
3.8	Welcome to Lane County basket: realtor contacts, tickets, vouchers, medical staff mentor, etc.	Ask for donations and organize baskets.	LCMS, PA & NP Recruiting Committee		4/30/2016	

KATE BROWN
Governor

May 21, 2015

Mr. Terry Coplin, CEO
Trillium Community Health Plan
P.O. Box 11756
Eugene, OR 97440-3956

Dear Mr. Coplin:

I am pleased to have received the request from Trillium Community Health Plan, the Coordinated Care Organization in Lane County, to designate the Lane County Physician Assistants and Nurse Practitioners shortage reduction effort as an Oregon Solutions project. After reviewing the assessment conducted by Oregon Solutions staff, I feel this project supports Oregon's Sustainable Community Objectives. This project will increase access to primary care by increasing the number of physician assistants and nurse practitioners being trained and working in Lane County. Therefore, I am designating it an Oregon Solutions project and appointing Debi Farr, Director of Government and Public Affairs for Trillium Community Health Plan, and Juine Chada, Field Representative for U.S. Senator Ron Wyden, as co-conveners.

The co-conveners will lead a team of primary care providers, health care organizations, and higher education organizations to create a plan to increase the number of physician assistants and nurse practitioners delivering healthcare services in Lane County.

This project can demonstrate how a team of community stakeholders from public sector, private sector, and non-profit organizations can work together to integrate and align their efforts in order to increase access to primary care in their community. While this effort is limited to Lane County, my hope is that the results will illustrate how other Oregon communities can increase access to primary care.

This is a positive opportunity for the Lane County community to move forward together. Success will depend on the connection and active collaboration among non-profit, private, and public sectors on the ground in your community. Please keep the governor's office updated on this effort and thank you for your work and enthusiasm thus far.

Sincerely,

Governor Kate Brown

Cc: Debi Farr, co-convener
Juine Chada, co-convener

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Appendix B	**OS-Lane PA-NP Participant List**	
Participant Name	**Title**	**Organization**
Barbara Johnson	DNP and Board Secretary	Lane County Nurse Practitioners Association
Ben Cho	Practice President & MD	Willamette Valley Cancer Institute
Betsy Boyd	Associate VP for Federal Affairs	University of Oregon
Brooke Emery	Senior & Disability Services Program Manager	Lane Council of Governments
Bruce Abel	Chief Behavioral Health Officer	Trillium Behavioral Health
Candice Barr	CEO	Lane County Medical Society
Chris Traver	Director	Sacred Heart Medical Center
Cindy Perry	Director Family Nurse Practitioners Program & PhD & FNP	Oregon Health and Science University
Debi Farr	Co-Convener	Oregon Solutions
Di Lacey	Assistant Vice President, Oregon Campus Operations	Western University of Health Sciences
Gary Halvorson	Medical Director & MD	Sacred Heart Medical Center
Hal Sadofsky	Associate Dean, College of Arts and Sciences	University of Oregon
Jackie Mikalonis	South Valley Regional Coordinator	Governor Kate Brown's Office
James Sims	DNP and President	Nurse Practitioners of Oregon
Jana Waterman	Vice President of Business Development & Marketing Director	McKenzie Willamette Medical Center
Jeff Thompson	Board Member	Springfield Chamber of Commerce
Jenny Ulum	Director of Public Affairs	PeaceHealth
Jim Connolly	Senior Vice-President for Provider Affairs	Trillium Community Health Plan
Jody Blasé	DNP	PeaceHealth
Jody Cline	Director Senior & Disability Services	Lane Council of Governments
Juine Chada	Co-Convener	Oregon Solutions
Louis Osternig	Professor, Department of Human Physiology	University of Oregon
Karen Gaffney	Assistant Director	Lane County Health & Human Services
Karen Weiner	Chief Medical Officer & MD	Oregon Medical Group
Kay Metzger	Innovation Agent	Oregon Health Authority
Laura Jacek	Assistant Dean, Graduate School	University of Oregon
Linda Caroll	Dean of Healthcare	Linn Benton Community College
Li-Shan Chou	Head of the Department of Human Physiology	University of Oregon
M.J. Kuhar	Interim Dean	Lane Community College
Mary Spilde	President	Lane Community College
Mary Von	Director of Physician Assistant Studies	Pacific University
Rep. Nancy Nathanson	State Representative	State of Oregon
Patrick Luedtke	Medical Director & MD	Lane County Community & Behavioral Health Clinics
Paula Schmidt	Chief of Nursing Officer & RN	McKenzie Willamette Medical Center
Rick Kincade	Vice President of Medical Affairs & MD	PeaceHealth

Rick Yecny	Chief Executive Officer	PeaceHealth - Florence
Sara Hodges	Associate Dean of the Graduate School	University of Oregon
Sheryl Berman	Dean of the Division of Health Professions	Lane Community College
Susan Bakewell-Sachs	Dean and Vice President of Nursing Affairs and PhD and RN	Oregon Health and Science University
Ted Ruback	Program Director of Physician Assistant Program and MS & PA	Oregon Health and Science University
Terry Coplin	Chief Executive Officer	Trillium Community Health Plan
Tim Herrmann	Chief Administrative Officer	PeaceHealth – Cottage Grove
Tricia Tully	Director of Nursing Program and RN & MS	Lane Community College
Tyra Jansson	MPH Candidate & Intern	US Senator Ron Wyden's Office
Jim Jacks	Project Manager	Oregon Solutions
Karli Dahl	Project Support	Oregon Solutions
	Additional Workgroup Participants	
Andrew Gilchrest	MD	Oak Street Medical Clinic
Gary LeClair	MD	PeaceHealth
Mark Meyers	MD	Springfield Family Practice
Ron Sherer	MD	PeaceHealth

Appendix C - Nurse Practitioner Oregon Legal Requirements

Definition Nurse Practitioners (commonly abbreviated as NP) are advanced practice registered nurses certified by the Oregon State Board of Nursing (per Division 50 of the Oregon Nurse Practice Act) that independently assume responsibility and accountability for the care of clients.[i] As part of a team and or independently, NPs can provide a full range of primary, acute and specialty health care services, including[ii]:

- Ordering, performing and interpreting diagnostic tests such as lab work and x-rays.
- Diagnosing and treating acute and chronic conditions such as diabetes, high blood pressure, infections, and injuries.
- Prescribing medications and other treatments.
- Managing patients' overall care.
- Educating patients on disease prevention and counseling patients on positive health and lifestyle choices.

Education and Licensing

Nurse Practitioner education begins at the master's, post master's or doctoral level followed by clinical coursework and rotations to acquire and demonstrate specialized knowledge.[iii]

In order to hold an Advanced Practiced Registered Nurse (APRN) certification in Oregon, all nurses must apply for and maintain both an Oregon Registered Nurse (RN) license and a valid, unencumbered national certification from an accredited national certifying body. Specifically, in order to practice, a NP must fulfill one of the following requirements[iv]:

- Completion of the qualifying NP program within two years from date of application. Applicants must include proof of a minimum of 384 practice hours within an RN scope on their NP application. These hours cannot be part of a continuing education program or completed for an academic clinical requirement, per OAR 851-050-0004(2)(a); OR
- Practice as an NP in the population focus for at least 192 hours within the past two years from date of application; OR
- 960 hours of NP practice in population focus within the last five years from the date of application.

To maintain Prescriptive Authority, NPs are required to qualify for, obtain, and maintain their Oregon APRN certification per Oregon Administrative Rule (OAR) 851-050-0002.[v]

The following specialties are recognized in Oregon:

NP Specialties Recognized in Oregon[vi]		
Acute Care (ACNP)	Geriatric (GNP)	Pediatric-Primary Care (PNP-PC)
Adult-Gerontology Acute Care (AGACNP)	Neonatal (NNP)	Psychiatric/Mental Health (PMHNP)
Adult (ANP)	Nurse Midwife (NMNP)	Women's Health Care (WHCNP)
Adult-Gerontology Primary Care (AGPCNP)	Pediatric (PNP)	
Family (FNP)	Pediatric-Acute Care (PNP-AC)	

[i] http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_851/851_050.html
[ii] https://www.aanp.org/all-about-nps/what-is-an-np
[iii] http://www.nursepractitionersoforegon.org/?page=12
[iv] http://www.oregon.gov/osbn/pages/advpraclicensure.aspx#APRN_Eligibility:_Nurse_Practitioner
[v] http://www.oregon.gov/osbn/pages/advpraclicensure.aspx#APRN_Eligibility:_Nurse_Practitioner
[vi] http://www.oregon.gov/osbn/pages/advpraclicensure.aspx#APRN_Eligibility:_Nurse_Practitioner

Appendix D - Physician Assistant Oregon Legal Requirements

Definition Physician Assistants (commonly abbreviated as PA) are healthcare professionals authorized by the state of Oregon through a licensing process to practice medicine under the supervision of a practicing physician.[i] PAs are eligible to perform many roles in patient care including[ii]:

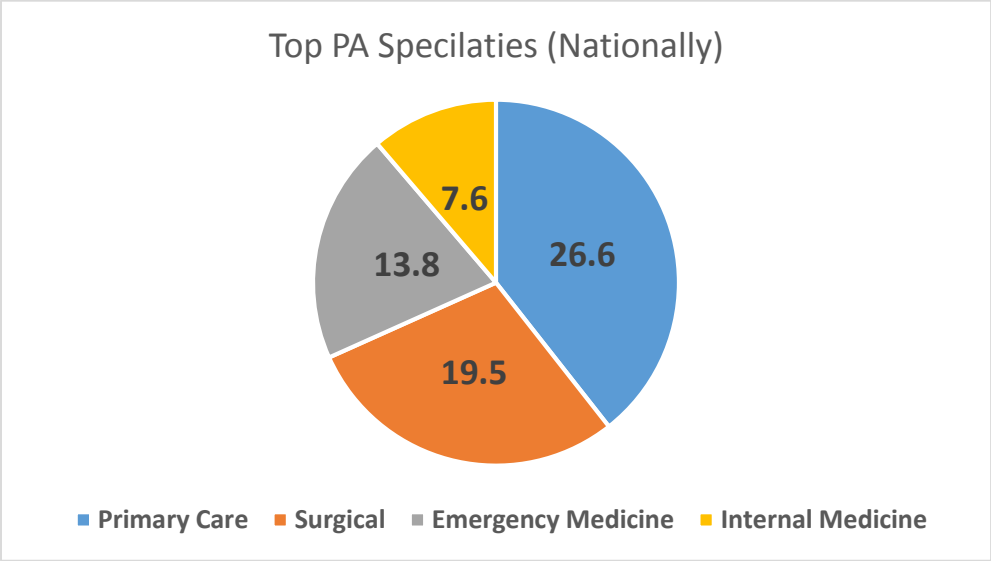
- Counseling on preventive care
- Conducting physical exams
- Ordering and interpreting tests
- Diagnosing and treating illnesses
- Developing treatment plans
- Assisting in surgery
- Writing prescriptions

Education and Licensing A person must meet the following eligibility requirements in Oregon to receive a PA license[iii] according to ORS 677.512[iv]:

- Graduate from a PA degree/training program that has been approved by one of the following accrediting bodies:
    - American Medical Association Committee on Allied Health Education and Accreditation (CAHEA)
    - Commission on Accreditation for Allied Health Education for Allied Health Education Programs (CAAHEP)
    - Accreditation Review Commission on Education for the Physician Assistant (ARCPA).
- Pass the Physician Assistant National Certifying Examination (PANCE) given by the National Commission on Certification of Physician Assistants (NCCPA).
- Apply to be licensed by the Oregon Medical Board

Note: The PA license must be renewed annually, requiring PAs to complete at least 60 hours of continuing medical education (CME) and pay a prorated fee.

Specialties According to a national survey conducted by AAPA, the following are the top specialties for PA professionals:



[i] http://www.theoma.org/membership/members-only/committee-sections-workspace/pa-section
[ii] https://www.aapa.org/What-is-a-PA/
[iii] http://www.oregon.gov/omb/licensing/Pages/Physician-Assistant.aspx
[iv] http://www.physicianassistantedu.org/oregon.html

Appendix E - Nurse Practitioner Salary Trends

Nationally and in Oregon

A national survey conducted annually by the peer-reviewed journal, *Advance for NPs & PAs*, shows that Oregon ranks at the top of compensation levels for Nurse Practitioners. Specifically, Nurse Practitioners in Portland reported an average salary of $100,170, and NPs in Eugene self-reported earning some of the highest salaries in the state, reporting an average of $110,000 in 2011. The American Academy of Nurse Practitioners reports that in 2011, average base salaries for the Far West region, including Oregon averaged approximately $97,567, with total average incomes at $107,518 when benefits were included. See table below for how Oregon compares to national trends:

Nationwide Salary Trends for Nurse Practitioners (Average) [i]							
	2015	2014	2013	2012	2011	2010	2009
Average Full Time Salary	108,643*	$101,621	$98,817	$93,032	$90,583	$90,770	$89,579
Average Part Time Hourly Rate		$55.02	$51.41	$48.49	$47.63	$43.77	$45.85

*According to the 2015 AANP National Nurse Practitioner Compensation Survey, the mean, full-time base salary was $97,083, with average full-time NP total income at $108,643.

Wage Range 2015 for Nurse Practitioners in Oregon[ii]							
Area	**10th Percentile**	**25th Percentile**	**50th Percentile (median)**	**75th Percentile**	**90th Percentile**	**Average Hourly**	**Average Annual**
Oregon	$39.26	$44.47	$52.35	$60.04	$70.82	$53.44	$111,159
Clackamas	$41.74	$49.77	$55.77	$61.89	$78.39	$57.49	$119,574
East Cascades	$37.08	$40.04	$44.58	$52.19	$58.02	$45.82	$95,314
Eastern Oregon	$26.62	$39.72	$44.50	$51.68	$59.41	$44.40	$92,360
Lane	$39.25	$42.08	$47.26	$55.52	$60.47	$49.69	$103,354
Mid-Valley	$38.20	$41.57	$46.95	$55.91	$73.52	$51.20	$106,488
Northwest Oregon	$38.85	$42.76	$49.29	$63.73	$75.61	$52.83	$109,889
Portland-Metro	$43.11	$49.55	$55.14	$61.33	$69.61	$54.89	$114,165
Rogue Valley	$35.00	$41.44	$50.57	$62.63	$74.74	$53.54	$111,354
Southwestern Oregon	---	---	---	---	N/A	$60.96	$126,799

[i] http://nurse-practitioners-and-physician-assistants.advanceweb.com/Web-Extras/Online-Extras/NP-Salaries-Continue-to-Rise.aspx

[ii] State of Oregon Employment Department query: https://www.qualityinfo.org/jc-oprof/?at=1&t1=nurse%20practitioner~291171~4101000000~2~false~false~true~false~false~false~false~true~true~false~false~false~false~none~0~1~1

Appendix F - Physician Assistant Salary Trends Nationally and in Oregon

PA Demand Projections

Though Oregon has approximately 1,337 certified PAs in 2014, Oregon still ranks in the middle around 25th in the country in terms of the number of certified PAs per capita.[i] The Oregon Employment Department sees an upward trend in job growth for PAs between 2012 and 2022. The agency expects this rate of increase to be 38.7% in Oregon and even higher in some regions of the state:

- Portland-Metro: 43.2%
- East Cascades: 41%
- Mid-Valley: 40.3%
- Rogue Valley: 39.5%

Current Salary Range in Oregon Compared to National Average

The median salary for Oregon's physician assistants was $101,962 in 2015. According to a national survey, the average salary of certified PAs was $98,387 with the highest pay going to specialists working in dermatology, emergency medicine, critical care medicine and surgery subspecialties[ii]. Below is the current salary range for PAs across the state of Oregon[iii].

Area	10th Percentile	25th Percentile	50th Percentile (median)	75th Percentile	90th[iv] Percentile	Average Hourly	Average Annual
Oregon	$38.89	$42.69	$49.02	$56.93	$66.93	$50.48	$104,988
Clackamas	$35.20	$43.26	$53.49	$72.76	$88.58	$57.71	$120,035
East Cascades	$39.31	$41.57	$45.35	$50.77	$57.29	$46.26	$96,225
Eastern Oregon	$36.06	$40.17	$45.61	$52.29	$56.99	$45.53	$94,695
Lane	$38.37	$41.98	$48.26	$56.23	$62.60	$48.84	$101,585
Mid-Valley	$37.44	$41.85	$48.08	$55.22	$62.81	$50.00	$104,009
Northwest Oregon	$38.90	$42.29	$47.80	$55.60	$68.25	$49.65	$103,275
Portland-Metro	$39.90	$44.05	$51.31	$58.55	$67.90	$51.41	$106,942
Rogue Valley	$39.84	$45.48	$52.44	$58.11	$64.83	$51.49	$107,099
Southwestern Oregon	$39.15	$42.11	$47.05	$55.39	$63.91	$48.09	$100,017

[i] http://www.nccpa.net/

[ii] http://www.nccpa.net/Uploads/docs/2014StatisticalProfileofCertifiedPAsPhysicianAssistants-AnAnnualReportoftheNCCPA.pdf

[iii] https://www.qualityinfo.org/jc-oprof/?at=1&t1=physician%20assistant~291071~4101000000~2~false~false~true~false~false~false~false~true~true~false~false~false~false~none~0~1~1

[iv] Salary data from the Oregon Employment Department further shows that experienced physician assistants in the 90th percentile earned 74.3% more than entry-level physician assistants earning in the 10th percentile as of 2015. Experienced physician assistants in Oregon earned an average of $139,214, while physician assistants new to the profession earned $79,849 on average. An analysis of the salaries of physician assistants by region indicated that physician assistants in Clackamas county earning in the 90th percentile made $42,286 more than those in the next highest paying region.

Appendix G

OS-Lane Physician Assistant – Nurse Practitioner Project Team

Preceptor Tax Credit Recommendation
11-30-15 version

The Lane PA-NP project team recognizes that this proposed tax credit idea could be significantly amended during the legislative process. It could also take a few legislative sessions before becoming law. This idea is a long term effort to increase the number of PAs and NPs providing primary care in Oregon.

The tax credit is intended to assist Oregon higher education programs with providing the community based educational resources students need to graduate and then work in primary care.

The Lane PA-NP project team supports many elements from the Georgia bill and has made some significant adjustments. Broadly speaking we agree to the following 6 things:

1. A preceptor is a licensed Oregon MD, DO, NP or PA providing community based training for medical, nurse practitioner or physician assistant students.

2. Community Based Faculty means a preceptor who provides a minimum of one and a maximum of ten rotations/practicums within a calendar year.
   "Rotation" is defined in the Georgia bill as:
   - 160 hours of community based clinical training
   - It can be accrued from multiple programs (students from multiple universities)
   - Hours do not have to occur within one student rotation

   In medicine the term "rotations" is used. While a rotation is usually 4-5 weeks long, some are 6, 8, or even 12 weeks long.
   In nursing the term "practicum" is used. A practicum runs the length of the term. For example, at OHSU the term length is 10-12 weeks and is 8 to 24 hours per week per student depending on where they are in the FNP program.

3. Preceptors must live in Oregon or work predominantly in Oregon.
   (For instance they might live in Vancouver, WA but work in Portland or live in White Salmon, WA but work in Hood River, etc.)

4. The only rotations/practicums available to receive the tax credit are: Family Medicine, General Internal Medicine (inpatient & ambulatory), General Pediatrics, OB/GYN, Psychiatry, Emergency Medicine, General Surgery, urgent care and geriatrics.
   (These are common rotations/practicums for primary care students.)

5. Preceptors are eligible if they are working with students enrolled in a (public or private) Oregon medical school, Oregon physician assistant school or an Oregon nurse practitioner school.

6. Preceptors are also eligible if they are working with students originally from Oregon even if they are attending a (public or private) pre-approved out of state medical school, pre-approved out of state physician assistant school or a pre-approved out of state nurse practitioner school.
   ("Originally from Oregon" means they graduated from an Oregon high school. If they grew up in Oregon they may want to return and preceptors should have an incentive to work with them.)
   (As per existing Oregon state law, students from out of state schools must be pre-approved by the Oregon Medical Board or the Oregon State Board of Nursing.)

The Lane PA-NP project team is open to the following idea:

- Could an <u>organization</u> be eligible for the tax credit instead of just individuals?
  A clinic/organization can experience a financial impact due to a reduction in productivity by the preceptor. We may need to include the organization if we want them to allow their staff member to participate as a preceptor. Some clinics/organizations providing service in Lane County are non-profit and do not pay taxes.

###

Appendix H – Federal and State Incentive Programs

Federal

National Health Service Corps (NHSC) Loan Repayment Program (http://nhsc.hrsa.gov/loanrepayment/loanrepaymentprogram.html)

- Many medical professions eligible, including PAs and NPs.
- Can get up to $50,000 to repay student loans in exchange for a two-year commitment.
- Can renew service commitment to receive additional loan repayment assistance.
- Service must be in a high-need, underserved area at a NHSC-approved clinic. (CHCs of Lane County participate in this repayment program.)

NHSC Scholarship Program (http://nhsc.hrsa.gov/scholarships/index.html)

- The scholarship pays tuition, fees, other educational costs, and provides a living stipend in return for a commitment to work at least 2 years at an NHSC-approved site in a medically underserved community.

- For each year of financial support (up to four years), the student agrees to serve one year (minimum two years) at an NHSC-approved site in a high-need urban, rural, or frontier community across the nation.

NURSE Corps (http://www.hrsa.gov/loanscholarships/repayment/nursing/)

- Can pay off up to 60% of nursing student loans in 2 years, pay off an additional 25% of original balance during a 3rd year.
- MORE

Advanced Education Nursing Traineeship (http://bhpr.hrsa.gov/nursing/grants/aent.html)

- Possibly not offered anymore? Last application year was 2014.

Indian Health Service Loan Repayment Program (http://www.ihs.gov/loanrepayment/index.cfm)

- Repays up to $40,000 in exchange for two years service in health facilities serving American Indian and Alaska Native communities.
- For many medical professions, including PAs and NPs.

Public Service Loan Forgiveness Program (https://studentaid.ed.gov/sa/repay-loans/forgiveness-cancellation/public-service)

- Must have made 120 qualifying monthly payments (ie at least 10 years) on student loans to be eligible.
- Available only for Direct Loans.
- Must be employed in a profession deemed by Student Aid as public service (PA/NP included).

Oregon

Oregon Partnership State Loan Repayment (http://www.ohsu.edu/xd/outreach/oregon-rural-health/providers/loan-repayment/slrp.cfm)

- For primary care providers (including PAs/NPs) working in Health Profession Shortage Areas.
- 2-year obligation, can receive up to $35,000/year in loan repayment.

Oregon Medicaid Primary Care Loan Repayment Program (http://www.ohsu.edu/xd/outreach/oregon-rural-health/providers/loan-repayment/ompclrp.cfm) (http://www.oregon.gov/oha/OHPR/rulemaking/notices/409-037_Web_Perm.pdf)

- According to OHSU website, this program was unfunded by the 2015 Oregon Legislature, and no new applications are being accepted.

Primary Health Care Loan Forgiveness Program (http://www.ohsu.edu/xd/outreach/oregon-rural-health/providers/loan-forgiveness.cfm)

- Must be already admitted and enrolled in an approved Oregon rural training track. Includes PA/NP.
- Must provide one year of clinical service in approved rural Oregon practice in exchange for each year of loans granted through this program.

Rural Practitioner Tax Credit for MDs, DOs, DPMs, NPs, PAs, and CRNAs (http://www.ohsu.edu/xd/outreach/oregon-rural-health/providers/provider-tax-credits/mds-etc-rules-2014.cfm)

- NPs and PAs must work at a rural practice.
- Up to $5,000 tax credit

Appendix I - List (partial) of Primary Care Providers in Lane County **OS-Lane PA-NP Declaration of Cooperation**

Organization Name	Address	Phone Number
Cottage Grove		
Cottage Grove Community Medical Center: PeaceHealth	1515 Village Dr. Cottage Grove, OR 97424	(541) 767-5500
Peace Health Medical Group	1515 Village Dr. Cottage Grove, OR 97424	(541) 767-5200
Prime Med Medical Clinic	1445 N. Gateway Blvd. Cottage Grove, OR 97424	(541) 942-7000
South Lane Medical Group	1515 Village Dr. #220, Cottage Grove, OR 97424	(541) 942-6614
Willamette Family	1450 Birch Ave. Cottage Grove, OR 97424	(541) 767-9956
Creswell		
Creswell Clinic	98 W. Oregon Ave, Creswell, OR 97426	(541) 222-7700
Creswell Health and Rehabilitation Center	735 S. 2nd St. Creswell, OR 97426	(541) 895-3333
Emerald Valley Wellness Clinic	300 N. Mill St. Creswell, OR 97426	(541) 895-5300
Eugene		
Applegate Medical Associates	655 E 11th Ave #8, Eugene, OR 97401	(541) 868-1876
Benson Health Clinic	66 Club Rd. Suite 160, Eugene, OR 97401	541-345-1722
Brookside Clinic	1680 Chanbers St. Suite 103, Eugene, OR 67402	(541) 682-3550
Charnelton Commuity Clinic	151 7th Ave #310, Eugene, OR 97401	(541) 682-3550
Crescent Family Medicine: Byfield Clyde MD	2830 Crecent Ave, Eugene, OR 97408	(541) 686-9000
Delta Oaks Clinic	1022 Green Acre Rd, Eugene, OR 97408	(541) 682-3550
Garden Way Medical Clinic: Buscemi Marie A MD	330 S Garden Way #350, Eugene, OR 97401	(541) 746-6816
LCBH Primary Care	2411 Martin Luther King Jr. Blvd, Eugene, OR 97401	(541) 682-3550
Oak Street Medical PC	1471 Oak St, Eugene, OR 97401	(541) 338-9494
Oregon Medical Group	4135 Quest Dr. Eugene, OR 97402	(541) 463-2195
Oregon Medical Group Chase Gardens North	330 S Garden Way #350, Eugene, OR 97401	(541) 746-6816
Oregon Medical Group Southtowne Medical Clinic	1835 Pearl St, Eugene, OR 97401	(541) 687-1688
PeaceHealth Medical Group	1200 Hilyard St, Eugene, OR 97401	(541) 685-1755
River Road Medical Group	890 River Rd, Eugene, OR 97404	(541) 688-0674
Santa Clara Medical Clinic	217 Division Ave. Eugene, OR 97404	(541) 688-2998
South Hilyard Clinic- Eugene Family Physicians	3525 Hilyard St, Eugene, OR 97405	(541) 687-8581
Westmoreland Pediatrics: Diehl M Tony MD	1650 Chambers St, Eugene, OR 97402	(541) 338-7787
White Bird Clinic	509 E 13th Ave. Eugene, OR 97401	(541) 342-1295

Florence

PeaceHealth Peace Harbor Medical Center	400 9th St. Florence, OR 97439	(541) 997-8412
PeaceHealth Medical Group	390 9th St. Florence, OR 97439	(541) 997-7134
PeaceHealth Family Practice	390 9th St. Florence, OR 97439	(541) 902-6105
McKenzie Willamette Primary Care		

Junction City

Juntion City Medical Clinic	355 W 3rd Ave, Junction City, OR 97448	(541) 998-6750
PeaceHealth Medical Group- Oregon	430 W 7th Ave, Junction City, OR	(541) 998-6314

Oakridge

Orchid Health	47815 OR-58, Oakridge, OR 97463	(541) 782-8304
Five Rivers Family Pracitce	48134 OR-58, Oakrige, OR 97463	(541) 782-4068

Springfield

McKenzie Pediatrics Children's Clinic	1442 S A St, Springfield, OR 97477	(541) 726-4100
Oregon Medical Group Gateway Medical Center	1007 Harlow Rd, Springfield, OR 97477	(541) 284-1600
Oregon Medical Group Valley Children's Clinic	2000 19th St, Springfield, OR 97477	(541) 746-5437
PeaceHealth Medical Group	3337 Riverbend Dr, Springfield, OR 97477	(541) 222-6000
RiverStone Clinic	2073 Olympic St, Springfield, OR 97477	(541) 682-3550
Springfield Family Physicians	2280 Marcola Rd, Springfield, OR 97477	(541) 747-4300
Timber Valley Medical Clinic	21 Hayden Bridge Way, Springfield, OR 97477	(541) 741-1226
Volunteers in Medical Clinic	2260 Marcola Rd, Springfield, OR 97477	(541) 685-1800

Appendix J - Clinical Rotation/Practicum Hours Needed

University	Clinical Rotation Type (family, internal, ED, OBGYN, surgery, etc.)	Student Type (NP, PA, MD, DO)	6 Week Rotation Duration (hours)	# Preceptors Needed per Rotation*
Pacific University	Family Medicine	PA	240	Minimum 1
Pacific University	Internal Medicine	PA	240	Minimum 1
Pacific University	In Patient Medicine	PA	240	Minimum 1
Pacific University	Surgery	PA	240	Minimum 1
Pacific University	Emergency	PA	240	Minimum 1

*Need as many preceptors as possible.
Our students can be mentored by PA's, MD's, DO's and NP's.

Sharing mentoring responsibility over several preceptors is preferred.

University	Clinical Rotation Type (family, internal, ED, OBGYN, surgery, etc.)	Student Type (NP, PA, MD, DO)	Rotation Duration (hours)	# Preceptors Needed per Rotation
OHSU FNP program	family practice	FNP	80-160 hours per 10-week term per student	Depends on clinic, ideal is to have one precpetor per student per term
OHSU FNP program	OB/GYN or midwifery	FNP	40 hours per 10 week term in summer per	Depends on clinic, ideal is to have one precpetor per student per term
OHSU FNP program	pediatrics	FNP	40-80- hours per 10 week term per student	Depends on clinic, ideal is to have one precpetor per student per term
OHSU FNP program	Urgent care, fast track ED	FNP	80 hours per 10 week term per student	Depends on clinic, ideal is to have one precpetor per student per term
OSHU FNP DNP program	specialty care (cardiology, orthopaedics, urology, endocrinology, dermatology and palliative care)		150 hours per 10 week term per student per specialty	Depends on clinic, ideal is to have one precpetor per student per term

Appendix K- Current (Aug 2015) & Future Student Placements

Current Placements

Location (Be Specific)	Number of Students in Past 2 years	PA or NP?	Main Contact Person for Growth in Capacity	Who knows Who? Who is willing to contact someone at this location at the appropriate time?
Northside Clinic (OMG)	2-3 ?	PA	John Brandon PA	He is easily accessible, but cutting back
PA PEDS Surgery (Eugene-Sp.)	1	NP	Chris Traver	Ditto
Family PH MGO (Eugene-Sp.)	6	NP	Chris Traver	Ditto
PH PEDS (Eugene-Sp.)	1	NP	Chris Traver	Ditto
PH Geriatrics (Eugene-Sp.)	8	NP	Chris Traver	Ditto
Emergency	6	PA	Chris Traver	
GI	2	PA	Chris Traver	
Peds Surgery PeaceHealth	2	PA	Chris Traver	
Family Medicine - Florence PeaceHealth	6	PA	Chris Traver	
Emergency - Florence PeaceHealth	1	PA	Chris Traver	
Trauma Surgery NWSS	1	PA	Chris Traver	
Cardiology - PeaceHealth	3	PA	Chris Traver	
Bariatric - PeaceHealth	1	PA	Chris Traver	
Family Medicine PeaceHealth	1	PA	Chris Traver	
O/B/Gyn Birth Center w/midwives PeaceHealth	1	PA	Chris Traver	
Orthopedics - PeaceHealth	1	PA	Chris Traver	
Lane County Health Dept	1	NP	?	

Future Student Placements

Location (Be specific)	**Student Capacity in 2-3 years**	**PA or NP?**	**Main Contact to forge a relationship?**	**Who knows who? Who is willing to contact someone at this Location at the appropriate time?**
Fertility Ctr of Oregon (Women's Care)	1 student per rotation	NP	Sue Armstrong	
PeaceHealth Nurse - Midwifery Birth Center	1?	NP/PA	Michelle Peters-Carr	MJ Kuhar
Oakridge-Orchid	?	NP/PA		Rick Yecny
PeaceHealth Creswell Clinic Family Practice	1 student per rotation	NP	Tim Herrmann/ Preston Cook	Tim Hermann
PeaceHealth Cottage Grove ED	1 student per rotation	PA	Danny Kranitz DO	Tim Hermann
Women Space	?	Both	?	
Volunteers in Medicine	?	Both	?	DeLeesa Meeshin Tubby
WhiteBird Clinic				Chuck Garard (sp?)
Lane County FQHC Community Health Ctr				Lane Co - Ron Hjelm/Bruce Abel
Springfield Family Practice				Kirk Jacobson
Oak Street Medicine				
Senior Health & Wellness	1 student per rotation/ 4 student per year	NP	Jan Brooke (Sacred Heart)	
University of ORegon Student Health Clinic	1 student per rotation	Both	Richard Brander	
LCC Health Clinic	1 student per rotation	Both	John Bauman	

Concept - Student NP/PA Clinic with dedicated preceptor

PeaceHealth Sacred Heart Medical Center | Center for Medical Education & Research

Duties and Responsibilities of
PHMG Clinical Physician Faculty

PeaceHealth Sacred Heart Medical Center ("SHMC", also known as "Clinical Facility"), an operating division of PeaceHealth, in collaboration with Oregon Medical Schools (" School"), operates a regional teaching program for medical students (the "Program"). SHMC, as used in this Exhibit A, shall have the same meaning as "Clinical Facility". The Program is being administered by SHMC, Center for Medical Education & Research ("CMER"). The Program provides for clerkship rotations for third and fourth year medical students at PeaceHealth Sacred Heart and other physician clinics including PeaceHealth facilities. The Program is successful in part because of the dedicated physicians who have agreed to assume clinical attending and precepting physician responsibilities. All physicians who are selected to be a member of the SHMC Clinical Physician Faculty ("Physician") shall carefully review the expected duties and responsibilities below and sign the corresponding Acknowledgement and Agreement to Duties and Responsibilities of Clinical Physician Faculty.

1) **Teaching Physicians at PeaceHealth Sacred Heart Medical Center:**
   a) **Attending Physician** shall provide such services as are necessary for the provision of clinical attending services including, but not limited to:
      i) Orient student to Program learning objectives;
      ii) Assist in development of clerkship schedule for the medical students;
      iii) Introduce medical students to SHMC unit support staff;
      iv) Insure that a process is in place to request permission for medical student involvement in patient care;
      v) Direct observation of medical students' basic skills and provide constructive feedback to medical students;
      vi) Provide a written final assessment of the medical students' performance for Clinical Course Directors and School Clerkship Director; and
      vii) Perform other duties relating to the Program as requested by PeaceHealth Sacred Heart.
   b) **Preceptor Physicians** provide an occasional teaching/mentoring role to students and will be referred to as clinical preceptors. Teaching responsibilities for preceptor Physicians will include coverage for attending physician throughout the clerkship/electives of third and fourth year students, direct observation of basic skills, teaching and guidance to the student and feedback to the attending physician.
   c) **Supervision.** Students assigned to Physician shall be subject to the oversight, supervision and direction of Physician. Physician is responsible for the care of all of Physician's patients involved in the Program, including all determinations of appropriate treatment and care of all such patients.

2) **All teaching physicians shall**:
   a) Comply with the CMS Department of Health and Human Services Guidelines for Teaching Physicians, Interns, and Residents. "*Department of Health and Human Services Guidelines for Teaching Physicians, Interns, and Residents" (December,2011).Center for Medicaid and Medicare Services*
      I. The only documentation from a medical or PA student that can be used for billing is past family, and social history (PFSH) and the review of systems (ROS) and must be co-signed by the teaching physician.
      II. All other documentation from that visit must be done in his/her own words by the teaching physician.
      III. The teaching physician must document that he/she performed the key or critical portions of the service and was directly involved in the management of the Patient's care.
      IV. The teaching physician may refer to the student's note (if present) and may also refer to the past family and social history and the review of systems from the medical student note (if present).
   b) Role model professionalism and respect for staff, patients, and families to create a caring atmosphere. Teaching clinical curricula is our primary responsibility but role modeling good behavior for our students is equally as important and will leave a lasting impression.

SCOPE: PeaceHealth Oregon Region

PURPOSE: To define the important educational role a physician faculty member will play in medical student education, whether they are the Clinical Attending physician to a 3rd or 4th year medical student or participating as a Preceptor.

POLICY:

1. **Attending Physician** shall provide such services as are necessary for the provision of clinical attending services including, but not limited to:
   1.1. Orient student to Program learning objectives;
   1.2. Assist in development of clerkship schedule for the medical students;
   1.3. Introduce medical students to clinical/SHMC unit support staff;
   1.4. Insure that a process is in place to request permission for medical student involvement in patient care;
   1.5. Direct observation of medical students' basic skills and provide constructive feedback to medical students;
   1.6. Provide a written final evaluation of the medical students' performance; and
   1.7. Perform other duties relating to the Program as requested by SHMC.

2. **Preceptor Physicians** will provide an occasional teaching and a mentoring role to students. Teaching Responsibilities for Preceptor Physicians will include coverage for attending physician throughout the clerkship/electives of third and fourth year students, direct observation of basic skills, teaching and guidance to the student and feedback to the attending physician.

3. **Supervision**. Students assigned to Physician shall be subject to the oversight, supervision and direction of Physician. Physician is responsible for the care of all of Physician's patients involved in the Program, including all determinations of appropriate treatment and care of all such patients.

4. **Beneficiary.** OHSU is a beneficiary of Physician's agreement to discharge these duties and responsibilities, and any change to these duties and responsibilities must first be approved in writing by OHSU.

5. **Documentation.** Comply with the CMS Department of Health and Human Services Guidelines for Teaching Physicians, Interns, and Residents. *"Department of Health and Human Services Guidelines for Teaching Physicians, Interns, and Residents" (December 2011). Center for Medicaid and Medicare Services*
   a) The only documentation from a medical or PA student that can be used for billing is past family, and social history (PFSH) and the review of systems (ROS) and must be co-signed by the teaching physician.

I. All other documentation from that visit must be done in his/her own words by the teaching physician.

II. The teaching physician must document that he/she performed the key or critical portions of the service and was directly involved in the management of the Patient's care.

III. The teaching physician may refer to the student's note (if present) and may also refer to the past family and social history and the review of systems from the medical student note (if present).

6. Role model professionalism and respect for staff, patients, and families to create a caring atmosphere. Teaching clinical curricula is our primary responsibility but role modeling good behavior for our students is equally as important and will leave a lasting impression.

REQUIREMENTS:

1. Physician shall maintain on an unrestricted basis:
   1.1. Licensure as a physician in the state of Oregon,
   1.2. Medical Staff membership and appropriate clinical privileges or staff status in good standing at SHMC, Cottage Grove Community Hospital, or Peace Harbor Hospital.
   1.3. Professional liability insurance for professional services and supervision of medical students in a form acceptable to SHMC with liability limits of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate.
2. All Clinical Attending Physicians shall sign an Acknowledgement and Agreement to Duties and Responsibilities of Clinical Attending Physician which outlines the term, termination policy, vicarious liability coverage and compensation for each physician.

PROCEDURE:

1. New Faculty Assigned to Student:

1.1. Verify that Faculty member is a member in good standing of SHMC Medical Staff with appropriate privileges or staff status and approved by Course Director.

1.2. CMER Director and Course Director will meet with new Faculty to review the overall goals and objectives of the Medical Education program as well as the Duties and Responsibilities of faculty and of the medical students prior to assignment of their first student.

2. Non-PeaceHealth Physician Faculty

2.1. CMER Director will send an Acknowledgement and Agreement of Duties and Responsibilities and Compensation Methodology Addendum to all physicians in group who have agreed to be on SHMC Faculty. A group officer will sign as well as each physician in group who has agreed to be on the faculty.

2.2. Agreements will be reviewed and renewed every 2 years by the PHOR Contracts Office and the CMER office.

2.3. The original document will be on file in the PHOR Contracts Office. An electronic version will be send to the physician group and a copy will be sent to Accounts Payable.

2.4. CMER office will submit quarterly check requests to accounts payable based on the number of students each physician mentored during the previous quarter.

3. PeaceHealth Employed Physician Faculty:

3.1. CMER Director will send Acknowledgement and Agreement of Duties and Responsibilities and Compensation Methodology Addendum to all employed physicians and request that they sign it as a new member of the SHMC faculty. This signed agreement will be in their filed with their Tab C.

3.2. CMER office will submit quarterly payment information to PHMG A/P based on the number of students each physician mentored during the previous quarter.

REFERENCES:

Clinical Attending Physician Roles and Responsibilities

Acknowledge and Agreement to Duties and Responsibilities

Faculty Compensation Plan by Department/Service – 2010-11

HELP: For questions or assistance with this policy please contact the Director of Center for Medical Education & Research

Clinical Attending Physician
Compensation Methodology

ADDENDUM

Third year required Clerkship (5 weeks):

$750 per student will be paid out to the assigned Clinical Attending Physician.

Fourth year required Selectives and/or Sub-Internships (4 weeks):

$625 per student will be paid out to the assigned Clinical Attending Physician.

Fourth year Electives (4 weeks):

$500 per student will be paid out to the assigned Clinical Attending Physician's group.

In the event that more than one Clinical Attending Physician is assigned to one student, these amounts will be divided equally according to the time spent with the student.

End of Policy

The last page of this policy document contains approval, review and revision information only.

CREATION (Original):

Author:	Ron Stock, MD, Medical Director and Chris Traver, Director		
Responsible Party:	Center for Medical Education & Research Clinical Course Directors		
Reviewed By:			
Approved By:	CMER Clinical Course Directors	**Date:**	7/12/2010

REVIEW:

Reviewer:	Chris Traver, Director	**Date:**	5/6/2012
Reviewer:	Julie Hughes, MD, Medical Director	**Date:**	5/6/2012
Reviewer:	CMER Clinical Course Directors	**Date:**	4/2012

REVISION:

Responsible Party:	Center for Medical Education & Research (CMER) Clinical Course Directors		
Revised By:	Chris Traver, CMER Director		
Approved By:	Gary Halvorson, MD, Medical Director, Julie Hughes, MD, VP for Medical Affairs and CMER Clinical Course Directors	**Date:**	5/2/2014
Reason/Summary of Changes:	1. Add 5. Documentation – PH System Office recommendation included in Medical Student Policy and added to Faculty Contracts. 2. Add 6. Role Model Professionalism as component of Service Excellence 3. Modified Addendum on Compensation Methodology to be consistent with Faculty Contracts.		

RETIRED:

Requested By:			
Approved By:		**Date:**	
Reason for Retirement:			

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PRECEPTOR APPLICATION FORM

Please Attach: 1) Preceptor's Business Card, 2) Copy of Medical License, 3) Curriculum Vitae, and 4) Malpractice Declarations Page

Preceptor's Full Name/Degree: _____ Supervising Dr. if PA/NP _____

Preceptor's Address: _____

Name of the Practice (as it appears on the business license): _____

Full name and credentials of Legal Signatory (usually the CEO, owner, medical director, etc.):

_____ _____ _____
Full Legal Name | Credentials (MD, DO, MBA, PhD, etc.) | Title (CEO, CFO, Medical Director, etc.)

Site Phone Number: _____ Site Fax Number: _____

Preceptor's Email Address: _____

Clinical Discipline: _____ Contact Person (If different from preceptor): _____

Willing to train additional PA Students? ☐ Yes ☐ No

Hospital Affiliations: List the hospitals used for inpatient care (if student will be taken to the facility) and the percentage of seen at that facility. Please note that facilities with less than 30% will not be processed.

Hospital Name and Dept. **EXAMPLE** **Sierra Sunset Hosptial; ER**	**Address:** **EXAMPLE** **123 State St** **Colton, CA 92301**	**Hospital Phone #:** **EXAMPLE** **909 555-1112**	**Medical Staff Office #:** **EXAMPLE** **909 555-1112 ext 104**	**%** **EXAMPLE** **70**

STUDENT TO COMPLETE IF STUDENT GENERATED ROTATION

Student Name: _____ Date Submitted: _____

Requested Dates for Clinical Education _____

I made initial contact on _____ (Date) and spoke with _____ (Name)

I have read and understand the requirements for generating my own clinical education _____ (Initials)

This form must be completed and submitted to the Clinical Education Coordinator(s) 90 days before the clinical education is scheduled to begin. If a student requests a rotation which involves a hospital more time will be required. The following boxes must be checked for approval of an **Out of Area Rotation** request.

☐ I acknowledge and accept the program policy for out of area rotations which requires the student to provide the Clinical Education Coordinator with transportation and room and board for out-of-area site visits.

☐ I did not contact another Physician Assistant Program to establish this rotation.

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PRACTICE PROFILE

1. Is this a group or solo practice? _____

2. For non-PA providers: Have you previously worked with a PA? ☐ Yes ☐ No

3. Does the office currently have mid-level practitioners? ☐ Yes ☐ No

4. Have you ever taught students in the clinical setting? ☐ Yes ☐ No

   If yes, please elaborate: _____

5. What is the average number of patients seen per day? _____

6. Will the student be mainly in the clinic? Will he or she be rounding on patients in the hospital?

   _____

7. Do you perform minor procedures in the clinic? If so, what type?

   _____

   _____

_____
Print Name

_____
Signature

_____
Date

Preceptor Requirements and Opportunities to Receive Continuing Medical Education (CME) Credit

Preceptor Priorities

In a 2000 survey that ranked desirable rewards for preceptors, the Medical University of South Carolina found that the following incentives were the top five priorities for practitioner respondents who have considered or have already played a preceptor role[i]:

1. Free registration or significant discounts on continuing education (CE) courses for self
2. Access to University library databases and electronic journals through the Internet
3. Reference materials, e.g., book, journal subscription
4. Free registration or significant discounts on CE courses for staff
5. University library privileges, including literature searches and document delivery
6. Adjunct faculty clinical appointment

Preceptor Protocol

The AMA requires preceptors to "exercise primary responsibility for patient care, not only supervising procedures in which the trainee participates but also overseeing the appropriate peri-procedure care" while specifically playing the following roles[ii]:

- Set objectives and develop the curriculum
- Oversee instruction and the practice of skills
- Demonstrate techniques and clinical procedures
- Evaluate the trainee

The AMA allows for one Category 2 credit per hour for teaching clinical rotations to medical students or PA students. This is self-reported for licensing requirements. However, there are different maximums on allowable credit. Through American Academy of Family Physicians (AAFP), for example, the maximum is 60 AAFP Prescribed credits to be reported during a three-year re-election cycle. In that context, teaching is considered a live activity.[iii]

Below is subsequent information for NP and PA specific requirements for serving as preceptors and the associated CME credit policies.

Nurse Practitioner Preceptor Requirements

AMA offers the following guidance for preceptor hours for credits for NPs:

AMA Guidance for NP Preceptors[iv]
Complete a minimum of 120 hours as a preceptor in which you provided direct clinical supervision/ teaching to students in an academic program that is related to your certification specialty, OR provide a minimum of 120 hours of clinical supervision related to your certification specialty to registered nurses in a formal registered nurse refresher or internship program that relates to your certification specialty.
Clinical nurse specialists and nurse practitioners must precept NP students in an academic program related to their certification specialties
Orientation preceptor hours are not accepted
Preceptor hours cannot be counted toward your certification practice hour requirement
Faculty may not utilize this category for clinical supervision of students in their educational program
Documentation: Complete the preceptor section of the Professional Development Record
Audit: If your certification record is audited, you will be required to submit a completed Preceptorship Documentation Form showing the hours, objectives, outcomes, and location of the preceptorship, signed by the institution responsible for the person being precepted.

Oregon Clinical Preceptors in the Nurse Practitioner program shall meet the following requirements[v]:

- (A) Student preceptor ratio shall be appropriate to accomplishment of learning objectives, to provide for patient safety, and to the complexity of the clinical situation;
- (B) Oregon licensure or certification appropriate to the health professional area of practice;
- (C) Functions and responsibilities for the preceptor shall be clearly documented in a written agreement between the agency, the preceptor, and the clinical program
- (D) Initial experiences in the clinical practicum and a majority of the clinical experiences shall be under the supervision of clinical preceptors who are licensed advanced practice registered nurses.

For NPS 100 contact hours are required every two years with CE hours being pro-rated from the date of graduation (not the date of licensure).

Physician Assistant Preceptor Requirements

AMA only recently allowed physicians to receive CME credit in 2013 for playing a preceptor role. AAPA and PAEA have partnered to follow suit by opening up Category 1 CME credit for PA preceptors with the following eligibility requirements[vi]:

1. Providers must be ARC-PA accredited PA educational programs.
2. Preceptors must disclose any financial relationship with commercial interests to PA students.
3. Preceptors must be fully licensed to practice at the clinical site where the training will occur.
4. PA programs are responsible for having a mechanism in place to document credits awarded.

The following credit award schedule has been developed by AAPA[vii]:

AAPA CME Credit Awards for PA Preceptors				
Number of Weeks	**Number of Students**			
	1	2	3	4
2	0.5 Credit	.75 Credit	1 Credit	1.25 Credits
4	1 Credit	1.5 Credits	2 Credits	2.5 Credits
6	1.5 Credits	2.25 Credits	3 Credits	3.75 Credits
8	2 Credits	3 Credits	4 Credits	5 Credits

Note: There is a maximum of 10 hours of Category 1 CME for clinical teaching per calendar year.

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[i] http://www.aahea.org/articles/june2.htm

[ii] http://www.ama-assn.org/ama/pub/education-careers/continuing-medical-education/physicians-recognition-award-credit-system/cme-help/guidance-new-procedure-cme.page?

[iii] http://www.aafp.org/cme/about/types.html

[iv] http://www.nursecredentialing.org/RenewalRequirements.aspx

[v] http://www.nursepractitionersoforegon.org/?page=119

[vi] https://www.aapa.org/twocolumnmain.aspx?id=1751

[vii] https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2109

TIPS FOR THE TEACHING PHYSICIAN

1. Prepare for the student (week before arrival)
    - Notify staff and colleagues of student's arrival
    - Review Student Profile
    - Set up student's work station (a place they can set up their laptop)
    - Plan the student's work schedule (especially consider what they can be doing on your day or afternoon off, and time they might spend with colleagues or other providers during the clerkship)

2. Orient the student
    - Introduce student to staff; explain their responsibilities and emphasize the staff's importance.
    - Tour the office and/or hospital; explain the workflow.
    - Sit down with the student and review his/her clerkship experience so far; career/specialty goals; and objectives for the course. Also review your expectations of the student including how the student will be evaluated and graded. This initial conversation is very important and is best done in a relaxed atmosphere, so setting aside some time for this the first day is a good idea.
    - Go over the work schedule, including call responsibilities if any.

3. Consider how you can improve the student's performance in any or all of the following areas:
    - Clinical skills (history, PE, presentations, procedures, problem solving)
    - Knowledge of your specialty
    - Communication skills (with patients, staff, colleagues, etc)
    - Professionalism and attitudes
    - Knowledge of ethical issues
    - Use of learning resources
    - Collaboration skills
    - Use of care resources (PT, home health, social workers, infusion center, etc)

4. Preceptor pearls
    - Give constructive feedback, as often as possible!! (see section on Feedback)
    - Directly observe the student interacting with patients; there is no substitute for this!!
    - Consider sometimes focusing your teaching on a given patient to just part of the total process (just the history taking, just the exam, or just the write

up). This saves time and keeps from overwhelming the student with too much information at once.
- If you don't know the answer to a student's question, have him/her look it up and report back.

5. Make it personal!!
   - Take the student "under your wing", make him/her feel welcome, special, and part of the team.
   - Help the student understand the lifestyle and career choices you have made.
   - Introduce the student to your family; invite them to dinner or a social outing.
   - Take the student to a local meeting or seminar.

6. Evaluation and grading
   - This can be uncomfortable for both student and preceptor but is necessary.
   - The key to making the process comfortable and constructive is the ongoing feedback given everyday throughout the clerkship.
   - Use the midterm evaluation to identify formally areas that need improvement by the end of the course.

7. Dealing with problems (see section on Attitudinal Problems)
   - Notify the Medical Director of any serious academic or behavioral/attitudinal problem early on so that corrective action can be taken.
   - OHSU course director and the Dean's office are also available to help and advise.

What Can We Learn from our Successful Clinical Preceptors?

ROUNDTABLE PRESENTATION
2007 PAEA ANNUAL EDUCATION FORUM – TUCSON, ARIZONA

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EDUCATIONAL GOALS AND OBJECTIVES

At the conclusion of this session, participants will be able to:

- Identify the characteristics of a successful clinical preceptor
- Describe ways to use the experience of successful preceptors to provide faculty development to new and established preceptors
- Discuss how to utilize what is learned from successful preceptors to develop recruitment tools to engage new clinical preceptors

INTRODUCTION

Recruiting and retaining clinical preceptors is a challenge many PA programs face. The reasons for this are varied and many. There may be logistical reasons such as transportation and housing issues for students. An emerging common obstacle is electronic medical records, which many practices are incorporating into their practices.

Preceptors may be reluctant to take a student into his or her practice because they perceive a negative impact on their clinical productivity. Preceptors often cite reasons of being too busy to have a student. Others believe that their patients would not be accepting of having a student in the practice.

BENEFITS OF BEING A CLINICAL PRECEPTOR

- Increased enjoyment of clinical practice.
- Sense of giving back to the profession.
- Decreased sense of professional isolation.
- Satisfaction in being a role model for students and playing a role in their professional development.
- Adjunct or volunteer faculty appointments to preceptors.
- Access to institutional resources, including the medical library, grand rounds and other CME offerings through the institution.
- CME credit for teaching

WHAT CAN WE LEARN FROM OUR SUCCESSFUL CLINICAL PRECEPTORS?

An analysis of OHSU students' evaluations of preceptors and rotation sites revealed that the preceptors who are rated most highly have the following characteristics:

Students feel welcomed in the practice by the preceptor, staff, and patients

Students are oriented to the clinic/hospital setting when they first arrive
Students have a space for a student to work in (work station, desk, etc)
Preceptor shows enthusiasm for teaching
Students are incorporated into the practice schedule

There is open and frequent communication with preceptor

Clear expectations of the student and preceptor are established at the outset
The preceptor is receptive to students' questions
Students receive immediate and frequent feedback (positive & negative)

Students are directly observed

Preceptors provide appropriate supervision of students' skills
Provides opportunities for constructive feedback

Preceptor takes and active interest in the student's learning

Student assignments such as researching a topic, online tutorials, etc
Taking time to discuss patients (particular the assessment and plan)
Allowing increasing student responsibility as the rotation progresses

In addition to the feedback students provide us with, as faculty, we also know that our best preceptors are those who:

- ✓ Familiar with and accepting of physician assistants
- ✓ Knowledgeable about the education and training of PA students
- ✓ Knowledgeable about the scope of practice of physician assistants
- ✓ Truly interested in teaching

"I'M TOO BUSY TO TAKE A STUDENT"

The classic teaching method of having the student see the patient and present the case, followed by the preceptor seeing the patient and teaching the student about the patient's case, is neither an effective nor efficient way of teaching or learning.

Data collected from Oregon Health & Science University demonstrate that it is possible for faculty to have be effective educators while maintaining high clinical productivity. Specific techniques that preceptors use to improve their efficiency, augment student learning, and improve patient care and satisfaction will be highlighted today.

"MY PATIENTS DON'T WANT TO SEE A STUDENT"

Most clinicians are very protective of their patients. Some preceptors may feel that nobody else can care for their patients the way they can. Others may assume that their patients don't want to see students. This seems to be particularly true in obstetrics and gynecology, and pediatrics. However, there have been some published studies[5-8] that have shown that care by medical students or residents does not compromise patient satisfaction.

DISCUSSION and WRAP-UP

For the next 25 minutes we will divide into small groups so that we can discuss how programs might utilize what we know about our successful preceptors to develop recruitment and faculty development tools to engage new clinical preceptors. In the final 15 minutes or so, we will ask someone from each group to summarize their group's discussion and ideas.

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Mastering the Preceptor Role: Challenges of Clinical Teaching

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ABSTRACT

This article aims to help both experienced and new preceptors become more effective teachers while maintaining their clinical workloads. A variety of strategies is essential to increase teaching effectiveness and decrease stress for the busy preceptor who juggles the roles of teacher and clinician. The article will begin with a review of role expectations and role strain factors for student, faculty, and preceptor. Principles of clinical teaching will be identified, followed by some strategies for teaching on busy days and concluding with suggestions for dealing with difficult students. J Pediatr Health Care. (2006) *20*, 172-183.

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Guided clinical learning experiences are essential to nurse practitioner (NP) education. The goal is to prepare clinicians to manage care with optimal health outcomes. The preceptorship has proved to be a highly useful strategy for clinical education. It allows education to be individualized, links classroom knowledge to real patient management problems, and provides for role modeling as the student develops standards and strategies for practice.

In the United States, preceptorships involve more than 500 hours of supervised clinical practice in the particular NP specialty with preceptors who are either experienced NPs or physicians in the same specialty. The student and preceptor have a one-to-one relationship. In the typical clinical practice teaching episode, the student does the assessment and presents the case to the preceptor with diagnosis and plan outlined, the preceptor validates the assessment and plan, the student implements the plan with assistance as needed, and the preceptor helps the student reflect on the case and its implications. As the student works with the preceptor over an academic term or more, he or she is expected to increase knowledge and skills, refine practice efficiency and effectiveness, and become increasingly independent in managing patient care. The preceptor provides constant feedback and support to the student and evaluation data to both the student and faculty (National Organization of Nurse Practitioner Faculty, 2000).

This type of teaching is not without problems, however. Irby (1995) noted that teaching in the clinical setting often occurs at a rapid pace with multiple demands on the preceptor; is variable in teaching and learning opportunities as cases vary unpredictably in number, type, and complexity; and

has a relative lack of continuity. In a busy setting, there may be limited time for teaching and feedback. In turn, the student may not find learning to be collaborative with the preceptor, may lack opportunities and time for reflection, and may find that independent learning is not at an optimal pace given the student's learning style.

A previous study of the preceptor as mentor (Beauchesne & Howard, 1996) concluded that preceptors may need help in identifying an individual student's learning style and in determining their own leadership style. Preceptor development is worth the time and energy needed because, if it is done successfully, the preceptor, student, and faculty all will benefit from more efficient, less stressful teaching by preceptors in clinical settings.

A survey by Burns (2003) for the Association of Faculties of Pediatric Nurse Practitioner Faculties of 350 preceptors attending the National Association of Pediatric Nurse Practitioners Annual Conference found that 89% preceptored because they felt an obligation to the PNP specialty and 85% did so because they liked teaching. Ninety-four percent said that they planned to continue precepting. Thus, despite the problems, preceptors find this role to be inherently satisfying.

This article addresses several strategies to increase teaching effectiveness while decreasing stress as the busy preceptor juggles the roles of teacher and clinician. It reviews role expectations and role strain factors for student, faculty, and preceptor; identifies some key principles of clinical teaching; suggests a variety of strategies for teaching on busy days; and concludes with suggestions for dealing with the difficult student. The goal is to help both experienced and new preceptors become more effective teachers while maintaining their clinical workloads.

ROLE EXPECTATIONS: STUDENT, FACULTY, PRECEPTOR

The roles of student, preceptor, and faculty must work in synchrony for good learning outcomes. The setting also is important and places limitations on time, space, and access to patients. The student is expected to be an active adult learner; the faculty is expected to assess the student's needs and arrange for a preceptorship learning environment consistent with program goals and to evaluate the student's work; and the preceptor is expected to provide day-to-day clinical teaching while meeting clinical practice expectations. Meeting the expectations is not always easy for any of the parties. More detailed role expectations as well as pressures upon role performance are summarized in Table 1.

Hayes (1994) studied the preceptor role and identified qualities of good preceptors from students' perspectives. Personal characteristics included being empathic, warm, respectful, and humorous. Flexibility, fairness, dependability, consistency, and enthusiasm were valued. Students also looked favorably on preceptors who were willing to work with the beginning student, could adapt their teaching style as needed, and supported the educational program. The preceptor is expected to have current clinical skills and knowledge, help students recognize their assumptions and think through their management decisions, and model effective communication with clients that emphasizes psychosocial aspects of care. Successful teaching is a complex process that requires not only expertise in clinical content but also positive personal attributes.

BASICS OF CLINICAL TEACHING

The following sections describe some general principles of teaching as well as specific strategies that can be used by the preceptor to help the student become a safe, competent, compassionate, independent, and collaborative clinician. This teaching spans the continuum from the basics of health promotion to the management of complex conditions and issues. Thompson, Kershbaumer, and Krisman-Scott (2001) suggest that preceptors teach critical thinking skills so that the practitioner is a *detective* in taking a thorough and focused history, *reflective* about the information gathered from the history and physical and ultimately *effective* in assessment, management, and follow-up.

Characteristics of Adult Learners

Familiarity with characteristics of adult learners is critical. Many NP students come to the clinical setting with a wealth of previous nursing experiences, whereas others may come from a non-nursing background with other unique experiences to enrich their nursing practice. Regardless of the type of their past experiences, adult learners are interested in sharing their history and merging their past lives into their new roles as NPs (Nebraska Institute for the Study of Adult Literacy, 2005). It is important to consider previous experience in the planning of clinical opportunities. Activities should include new experiences, such as care of older children for the former NICU nurse, as well as application of previous skills to new situations to help students integrate important aspects of their previous lives into their NP training.

Adult learners are often experiential learners who prefer to take an active part in the learning process rather than being passive recipients of information. Ideally, NPs view learning as a problem-solving activity rather than just an information-gathering activity. This problem-solving focus is significant in the development of es-

Table 1. Role expectations and pressures

Student	Faculty	Preceptor
Role expectations		
Arrange schedule	Identify and secure appropriate sites for students	Orient student to site, policies, procedures
Develop personal learning objectives	Prepare student with necessary clinical skills	Facilitate informal, collaborative, respectful learning environment
Address course objectives	Provide preceptor with course objectives	Be a positive and effective role model
Observe policies and procedures of agency	Visit site during student experience	Provide learning experiences with appropriate patients
Confer with preceptor and faculty about progress and problems	Support and help preceptor develop teaching skills	Provide on-going feedback
Prepare for each clinical day	Monitor and evaluate student progress	Pace learning experiences to meet student needs
Review and read about past day's work	Provide evaluation feedback to preceptor	Direct student to resources, readings
Evaluate faculty, course, and preceptor	Solve student and/or preceptor problems with the rotation	Notify faculty of concerns about student's behavior, work, or progression
	Guide student clinical learning through class, chart reviews, case studies, assignments	Provide evaluation data to preceptor
	Provide feedback to student	
	Teach clinical reasoning and skills from own knowledge and experience	
Role pressures: potential areas of difficulty		
Make connections between didactic and clinical work	Identify preceptors and appropriate settings that meet student learning needs in a time of preceptor shortage	Teach from experience base
Work according to prescribed trajectory for clinical progress	Evaluate student progress indirectly through written documentation and short visits to the site	Maintain patient care service expectations
Balance adult life with student expectations	Keep learning expectations from impacting too greatly on preceptor service demands	Fit clinical teaching into the program's curriculum
Achieve learning needs within a service environment	Orient and develop preceptors within their time and interest constraints	Maintain rapport with patients and families while involving student in a meaningful way
	Reward preceptors for their work	Persuade colleagues to assist with student education
		Convince administration to permit students at site

sential critical thinking skills. They need to understand the "why" behind what they are being taught and what they are expected to do (Knowles, 1984; Nebraska Institute for the Study of Adult Literacy, 2005). For example, actually prescribing immunizations is more valuable than reading about the process or watching the preceptor perform the activity. Adults typically learn better when the topic is of immediate value.

General Approaches for Adult Learners

Just as there are principles of adult learning, there also are principles of teaching adults in the clinical setting. The most commonly described teaching methods are the "sink or swim" approach and the "manipulated structure" approach (Davis, Sawin, & Dunn, 1993). Use of these approaches generally change over time as the student develops more skills and confidence. In the "sink or swim" approach, the student NP is exposed to a variety of patient encounters and is expected to conduct visits independently with no visible support. With this approach there is minimal pre-visit teaching but, obviously, the preceptor is ultimately responsible for important decisions and is available at all times for back up. In the structured approach, patients are carefully selected, based on the student's previous experience and skills. There is much pre-visit and post-visit consultation with the preceptor. Cases increase in number and complexity as clinical skills develop. Preceptors generally teach as they like to learn but need to recognize that their students may not share the same perspectives.

Several important factors must be considered when deciding which method of teaching to use. It is helpful to consider the level of the student. A first-semester, first-year student may function best with a structured approach, whereas a final-term student is likely to be ready to "swim." It is appropriate to ask NP students what approach they prefer. If new students opt for the "sink or swim" approach, it is critical that they be closely monitored until the preceptor is comfortable with their skills. Observing those students independently conduct a visit may allow

the preceptor to judge their current abilities and subsequently structure clinical experiences according to abilities. Preceptors may find that consultation with university faculty is useful when deciding which approach to use. An important principle to keep in mind regarding use of teaching styles is that anxiety may result from a learning situation requiring high independence with low experience, while frustration occurs when low independence is allowed for students with high experience levels.

Principles of Clinical Teaching

After determining what specific teaching approach is best for the student and for the clinical setting, it is useful to apply general principles of clinical teaching. Some basic tenets of learning include the following:

- Learning is evolutionary.
- Participation, repetition, and reinforcement strengthen and enhance learning.
- Variety in learning activities increases interest and readiness to learn enhances retention.
- Immediate use of information and skills enhances retention

Preparation and planning. In addition to the personal qualities of the preceptor that have already been mentioned, preparation and planning have been noted by several authors to be key components to a successful experience for all students (Fay et al., 2001; Smith & Irby, 1997; Usatine, Nguyen, Randall, & Irby, 1997). The goal is to provide settings and experiences in which learning can occur with minimal disruption to agency operations and patient needs and expectations. Awareness of the school's goals as well as the student's personal goals is essential. Thus, there needs to be communication with faculty prior to the student's arrival and discussion of goals with the student before beginning clinical activities. Preparation of the clinical setting, one important aspect, will be discussed later.

Teaching strategy options. Regardless of whether a "sink or swim" or a "manipulated structure" approach is used, several specific strategies of teaching are useful for all levels of learners. *Modeling* is an effective teaching strategy (Irby, 1995). The preceptor demonstrates his or her clinical expertise when seeing patients while the beginning learner observes this process. This approach allows the student to see the reality of classroom education applied to actual patients. Modeling allows the more advanced learner to observe more subtle aspects of patient interaction, such as how one approaches difficult issues of potential physical abuse, problematic behaviors, developmental delays, and serious illness. *Observation* and modeling provide the preceptor and the student with the opportunity to share impressions, think through cases together, and develop differential diagnoses. It is often during this modeling experience that the preceptor may be challenged to answer the "why" questions of adult learners. However, modeling and observation are relatively passive; learners need to actually apply skills themselves to achieve mastery.

Case presentations reflect the student's ability to obtain critical histories, report pertinent physical findings, generate reasonable differential diagnoses, and develop fitting management and follow-up plans. Discussing cases allows the preceptor to determine if the student is able to incorporate past experience and schemata into new clinical situations and assess the student's level of expertise in dealing with a range of patients (Coralli, 1989; Wolpaw, Wolpaw, & Papp, 2003).

Direct questioning is helpful in fostering critical thinking skills. Preceptors are most effective when the questioning is not perceived as "grilling" (McGee & Irby, 1997). Optimally, questions such as "What do you think?" and "Why do you think that?" stimulate thinking and allow the student to share observations and interpretations with the preceptor. The preceptor can help the student formulate generalizations, which then can be tested with multiple patients. Generalizations then become part of a conceptual framework, which will be useful over time (Smith & Irby, 1997).

Two types of questioning methods are discussed in the literature. An especially useful approach to teaching when time is very short is the "One Minute Preceptor Method" described by Neher, Gordon, Meyer, and Stevens (1992) and evaluated for effectiveness in several studies (Aagaard, Teherani, & Irby 2004; Irby, Aagaard, & Teherani, 2004). This strategy requires the preceptor to get a commitment from the student about what the student thinks is going on after seeing a particular patient. The preceptor then challenges the student to provide supporting evidence for the assessment. This enables the student to draw from previous clinical experiences, as well as coursework and readings. The preceptor gives immediate feedback to the student about what was correct about the assessment and helps the student recognize some general rules that applied in the specific situation (Table 2).

The "Think Aloud Method" (Lee & Ryan-Wenger, 1997) requires the student to provide a rationale for specific questions that were asked and physical examination techniques used to show how conclusions were reached. This approach fosters critical thinking and clinical reasoning skills. It is useful with all levels of learners but especially for the beginning student, because it requires the student to verbalize thoughts and support decisions. For example, the preceptor will

Table 2. The One-Minute Preceptor Technique

Learning goal	Script	Rationale
1. The student is to make a decision regarding the case at hand	"What do you think?"	This question is helpful throughout the decision-making analysis—from making a diagnosis to working out a plan; the student is not simply providing information to the preceptor to make decisions
2. Probe for supportive findings and evaluate the critical thinking that led to the decision	"Why do you think that?" "What led you to that conclusion?" or "What else did you consider and rule out?"	Diagnose the learner's understanding—gaps and misunderstandings, poor reasoning or attitudes; do not ask for textbook knowledge
3. Tell student what was right in the conclusions and critical thinking	"Specifically, you did a good job of _____ . . . and this is why it is important. . . ."	State specifically what was done well and why it was important to reinforce excellent performance
4. Correct student errors	"You did well based on your knowledge of older children but didn't factor in the infant's development"; "I disagree with . . ." ; "A more efficient way. . ."	Specific correction will reinforce correct ideas and extinguish incorrect ones
5. Teach a general principle/ clarify the take-home lesson	"The key point I want you to remember is . . . ."	Point out key ideas, prioritize essential points among many details
6. Your own one-minute reflection	"What did I learn about my teaching?", "What did we learn from this?"	Place exercise into larger context of patient care and refocus for teaching episodes

Adapted from Neher, Gordon, Meyer, & Stevens, 1991.

ask, "Why did you ask about fever?" This approach works well in clinical seminars conducted by faculty.

Assigning directed readings on specific clinical topics that arise during visits is helpful. The literature reinforces general rules and fosters the development of conceptual frameworks. Directed readings are especially important for beginners because they may not have enough experience to determine where to find the best information in the nursing or medical literature. The preceptor suggests readings and asks for a brief report at the next session.

Coaching is another excellent teaching method. In this process, the preceptor provides verbal cues to the student as he or she moves through a procedure. The intent is to keep the student safe and efficient while mastering the steps of a skill that may not yet be automatic in nature.

Feedback from preceptors is critically important, especially with adult students whose learning is enhanced if they believe they are making progress (McGee & Irby, 1997). Effective feedback is descriptive of specific situations and skills and is given soon after the preceptor's observation of these concrete events. It reinforces what has been done correctly, reviews what needs to be improved, and corrects mistakes. Feedback is less judgmental than evaluation and is best given informally throughout the student's experience. Feedback is sometimes more meaningful if the student has the opportunity to do a self-assessment prior to hearing the preceptor's comments. For example, a conversation regarding the question, "How well do you think you addressed this mother's concerns?" will give the student the chance to share his or her rationale for the approach while also prompting the further discussion about the question, "How could you have done this differently?"

Evaluation. Evaluation is an important component of the preceptor/NP student relationship. The preceptor needs to be familiar with the university curriculum, the university's goals and objectives for the specific clinical experience, and the evaluation tool that is required by the school at the conclusion of the placement. Having a good sense of what knowledge base the student is expected to have will be helpful. In addition to the expectations of the university and the preceptor, it is helpful to address the student's personal goals for the clinical experience. Realistic goals are best met if they are written down and discussed early in the experience as well as periodically throughout the rotation. An evaluation session midway through the term and at the end of the rotation is essential. The student should be encouraged to self-evaluate as well as to receive evaluative information from the preceptor. Of course, the preceptor's evaluation also needs to be

shared with the faculty person who is responsible for grading the student's performance.

Teaching to the Developmental Level of Students

It is important to remember that while being a preceptor is stressful, so is being a student (Yonge, Krahn, Trojan, Reid, & Haase, 2002). Examining the situation from both perspectives is one way to better understand the relationship (Papp, Markkanen, & von Bonsdorff, 2003). Ohrling and Hallberg (2000) studied students' lived experience of preceptorship. Four themes emerged as critical to learning: creating a space for learning with both time and room, providing concrete illustrations, providing for some control over the opportunities and pace of learning, and allowing time for reflection. Taking advantage of students' past experiences and expertise is helpful. Also, students' self-esteem is enhanced when they believe they are contributing to care (Hayes, 1998). Preceptors should not feel threatened if students are more expert in some areas of nursing, but rather, seize the opportunity to learn from the student. Because students are experiencing the stresses resulting from being an expert in a previous nursing area to now becoming a novice again (Benner, 1984), recognition of their expertise is helpful to them.

In order to best apply the basic strategies of effective precepting, it is important to be familiar with specific developmental levels of NP students. As with all students, they fall along a continuum of development. Students develop at different rates, react differently to different patients, and may have variability in their skills from day to day. However, there are general categories of students, each with specific skill sets (Davis et al., 1993).

The beginner. Beginning or advanced beginner students typically need preceptor support for all facets of clinical learning. They have had core course work in health assessment and perhaps some management coursework but have had little opportunity to apply classroom concepts to actual patient care. They may have difficulty in transitioning from being an expert in their previous nursing roles to being a beginner in the NP role. Some students will be reluctant to begin assessing patients independently, whereas others may be very assertive in the clinical setting, even without any prior nursing experience, using a "sink or swim" style of learning. A preceptor can use observation of the student to determine what student skills are strong and which need particular attention during the clinical experience.

Several specific strategies are useful for beginning students. Observation is a reasonable initial strategy. The student can learn much about approaches to patients as well as clinical content from observing an expert. Students must not stay in the observer mode, however. If possible, straightforward, uncomplicated, "routine" well visits should be scheduled with families who are familiar with the beginning NP role. Prior to each visit, beginning students should spend time thoroughly reviewing each chart and preparing all components of a health promotion or uncomplicated illness visit. Several patients of the same age in a session reinforce developmental milestones. General rules and conceptual frameworks around different issues and different ages then develop.

The transitional learner. After some initial weeks or months as a beginner (depending on the intensity of the clinical experience and the student's abilities), it is expected that a student will move from beginner status to transitional learner. According to Thompson et al. (2001), this is the stage in which the preceptor is able to "step back." Transitional learners require less input from the preceptor about the basic components of patient care. Thus, pre-visit and post-visit conferences can be more concise. The student establishes basic priorities for each visit, gathers only essential relevant data, and generally conducts visits with better efficiency and effectiveness (Davis et al., 1993). The task of the preceptor in teaching transitional students is to schedule more complex patients so that more multifaceted generalizations develop and clinical reasoning skills are stretched to a new level. Case presentations, the "think aloud" method, and assigned readings continue to be effective strategies for transitional students.

The competent proficient learner. The final type of student learner is the competent proficient learner. This student has solid skills in history taking, physical assessment, evaluation, and management, as well as increased clinical judgment and the ability to relate past clinical situations to current situations (Davis et al., 1993). This student is more flexible in thinking about cases because he or she has previous experience to draw upon and is more time efficient and comfortable with the advanced practice role. Thompson et al. (2001) describe this stage as one in which the preceptor can "step out." Competent proficient students, like all experienced clinicians, are aware of their limitations and still ask questions and seek the input of clinicians with more knowledge. The focus of precepting a competent proficient learner is on pattern development and the use of schemata or general representations, seeing which can be applied across patients. Competent/proficient students should see more medically and socially complex patients within designated time frames.

As the student nears the end of later clinical rotations, it is important for the preceptor to know when it is time to let go and allow

the student more independence. The relationship with the preceptor often becomes more collegial and less vertical, mutual trust develops, and the preceptor is comfortable with the student's skills and clinical judgments. Strong case presentation skills in the competent student allow the student to communicate well with other providers. It is time to let go when the preceptor is comfortable with the student's competence with patients, but the student must continue to seek help, ask appropriate questions, and search for new challenges.

STRATEGIES FOR TEACHING WHILE PRACTICING ON BUSY DAYS

A common question posed to faculty is, "How can we have a student on a particularly busy day?" The reality is that every day is a busy day in the clinical setting. Nurses are in short supply, and faculty and preceptors are not the exceptions. Thus, all are assumed to carry heavy clinical loads. Factors in the shortage include aging faculty, increased clinical burdens that lessen time available to teach, and a major emphasis on productivity in the clinical arena (Lyon & Peach, 2001). Guberski (2000) summarizes the dilemma facing all clinical faculty: "The challenge facing current faculty is to work smarter, not necessarily harder, and to evaluate the cost-benefit ratio of our teaching strategies and application of technology" (p. 5).

Several studies have dispelled some powerful myths about precepting. Preceptors do not necessarily have a longer day or spend more time with patients, and having students does not inevitably decrease productivity (McKee, Steiner-Grossman, Burton, & Mulvihill, 1998). In fact, students may actually increase productivity (Fontana, Devine, & Kelber, 2000; Hildebrandt, 2001). However, working with a student undeniably makes a clinical day more complex. Reducing the complexity wherever possible is the key to enjoyment of the day when a student is there.

Taking the time to develop an optimal climate for learning will pay off for all persons involved. Students learn best when there is ongoing student assessment, close communication, quick response to student's stress, trusting relationships, mutual respect, and acceptance as part of team (Myrick & Yonge, 2001). Frequently expressed barriers to being an effective preceptor and a clinician at the same time include the following: feeling overworked, being unprepared for teaching, being mismatched with students, lacking adequate time, and receiving insufficient feedback and guidance (Hayes, 2001; Yonge et al, 2002). Avoiding as many pitfalls as possible is important for both preceptor and student.

Preparing for the Day

To be successful on a busy day, it is essential to do good pre-planning. Preparation of the clinic setting is essential. All members of the practice setting must be aware of the student's arrival and expected length of stay both in terms of daily schedule and length of calendar time to be spent in the setting. Such things as scheduling patients, arranging examination room availability, providing space for charting, and planning for student access to patient records need to be addressed.

It will also help to meet the student for the first time before the first day of the rotation by planning for a brief student interview before the first day begins. Discussion should include a review of the student's goals, learning style, and past experiences. The student can be asked to arrive with a questionnaire including this information and contact information already completed. The preceptor also needs to share some of his or her history and usual teaching style. The preceptor should describe the agency, the types of conditions cared for, and the mission of the agency. Any specific standards or guidelines that the site has in place governing student behavior or NP roles need to be shared at this time. A tour of the site and introduction to staff will help.

Each day of the preceptorship, further planning should occur. Review of the appointment list for the day and identification of appropriate patients for the student to be involved with is a good idea. The preceptor needs to communicate clearly to the student the expectations with regard to numbers and types of patients seen, amount of time available to spend with each patient, and amount of preceptor time available to the student. Clearly delineated expectations help the student perform as optimally as possible while not compromising the care of patients. Explaining where the difficulties lie and where the learning opportunities will likely appear is essential.

The expert preceptor is constantly doing "invisible planning"—thinking ahead about other activities that will be helpful to the student's progress (Skeff, Bowen, & Irby, 1997).

Students want to be helpful and involved in clinic work. They also are using the preceptor as a role model to see how clinicians problem-solve clinic management issues. Focus on the student by stating such plans as, "We will review the cases for the morning over lunch," or "Keep a 3 × 5 card for questions you have during the day and we will address them for 20 minutes at the end of the day or when we have a break in the schedule."

Use of Other Resources

Thinking broadly about the student's education is useful. Preceptors often feel guilty about using others' expertise and resources in the practice setting (Kaviani & Still-

BOX 1. Tips for teaching on busy days

Pre-planning

1. Prior to the clinical experience, describe to the student the pressures you face.
2. Get to know your student's learning style and needs before the first day of patients.
3. Review the cases for the day with the student and mutually decide where the best learning opportunities are likely to arise.
4. Have some other ideas in mind for times when you cannot teach for one reason or another. For example, student can listen in on triage phone calls, follow-up by phone with cases seen previously, go with another provider who likes to teach, spend time with the laboratory technician or pharmacist, or use the Internet to answer a question that had been unanswered from a previous discussion.
5. Set priorities for the student to accomplish and activities to complete by the end of the day.

Student time with patients

1. Work together with one patient to decrease the time spent and allow the student to see your assessment and care for efficiency. Have student do the history, and then you do the physical. Rotate tasks for the next patient.
2. Help the student recognize what to include in a focused history and examination for the presenting concern without going onto contextual or tangential issues.
3. Assign the student to patients whom you know like extra time.
4. Set a time limit on the student: "Get as much of the history as you can in 10 minutes and I will come in."
5. Schedule your patients in waves: two in time slot 1, one in time slot 2, and none in time slot 3. In the first time slot, you and the student start out in different rooms at the same time. You do a second case in time slot 2 while the student finishes his or her case and prepares to discuss it with you. Use the break in time slot 3 for completion of the student's case, charting, and preparation for the next wave. You will have kept your productivity numbers at three cases in three time slots.
6. Go into the patient's examination room with the student and chart the history and physical while the data are being collected by the student. Then reverse roles and have the student document while you gather the data.

Case presentation time

1. Set a limit on length of presentation time. "Tell me the H & P, diagnosis and your plan in 5 minutes."
2. Ask the student to present while both of you are in the room with the patient. (Be careful if there is psychosocial information or other factors that should be communicated and discussed privately between you and the student first.)
3. Assign the student to patients you know well, as this may speed evaluation of accuracy of student data. Also, give the student background on the patient to help focus the history more efficiently.

Finding discussion time

1. Ask the student to keep a file card handy to write down questions for discussion later. Follow up daily for 15 to 20 minutes.
2. Use travel time to and from clinic or to lunch to discuss cases.
3. Set limits on time for encounters. "I can meet with you for 10 minutes now. You can have 5 minutes to ask me questions and then I want to give you some feedback on the patient we saw together this afternoon."
4. Ask the student to look up information on three cases you saw during the day, but make it clear that you will ask for a report the next session on only one of the three cases.
5. Jot down patient care pearls that arise from various sources. Collect them on a list and share with the students.
6. Honor your appointments with students. Keep them brief but focused.
7. Expose students to the complete day. Take them to noon conferences, committee activities, and civic activities.

well, 2000; Yonge, Ferguson, Myrick, & Haase, 2003). Yet, it is better to share the teaching. Students benefit from enriched learning opportunities. These might include arranging for students to attend rounds, case conferences, or any other relevant meetings that focus on care. Use the library, audiovisual aids, and learning centers. Preceptors can establish a buddy system with a colleague to share students occasionally. Teaching also can involve use of online resources and exercises. Perhaps there is another clinician who has something special scheduled for the day. Would a morning with a laboratory technician be helpful? What about a couple of hours with the nurse doing telephone triage or follow-up? Would it be informative for the student to call some patients to evaluate care given earlier? Creative ways of assessment and evaluation of learning in addition to direct observation will be helpful, particularly if planned for efficient use of time (DaRosa et al., 1997).

Trimming Time off Teaching Activities

Listed in Box 1 are some strategies that can be adopted for teaching on busy days. They relate to pre-planning, student time with patients, case presentation time, and finding discussion time.

A scheduling strategy that might work in some practices but not others, at least formally, is to schedule patients in waves—two in slot 1, one in slot 2, and none in slot 3. That will let the preceptor and student each start off with a

patient to see (slot 1). The preceptor can continue with the third case in slot two while the student finishes his or her case. The break in slot 3 will give time for teaching before the next round begins. In terms of the whole day, three patients will have been cared for in each three time slots. Whether formally scheduled or not, the principle holds as a way to carve out teaching time in the midst of the clinic work.

It is essential that preceptors be realistic about the amount they attempt to teach. Small bits are fine. It is also essential to give feedback daily, keeping it short and directed at the care given that day. Vary teaching strategies depending on time, student need, and level and clinical opportunities.

Evaluating the Teaching Day

Evaluation of the teaching day should occur routinely. One particular example may be called the "End of Day Newspaper Review" technique. Thinking briefly about who was seen, what got done, how the student felt about it, where the student wants to go next, and why things worked or did not can be very helpful when done on a routine basis.

Every preceptor needs some fundamental skills, what may be termed "preceptor know-how." A skilled preceptor knows how to navigate the clinical system, knows how to create a climate for learning, and knows how to get the expected work done (Mamchur & Myrick, 2003; Myrick & Yonge, 2002). Role modeling, guiding, facilitating, and prioritizing are key concepts for the busy preceptor to keep in mind. Strong organizational skills and the ability to set priorities may be critical factors in success for precepting in a busy setting. Morrow (1984) has clearly delineated the priority setting process. A good prioritizer carefully identifies the activities that are important, essential, time sensitive, urgent, and/or must be completed on time. Distinguishing between the activities that must be accomplished today versus those that would be nice to do is an essential skill.

WORKING WITH THE DIFFICULT STUDENT

Although the preceptorship is a positive experience for all parties the majority of the time, problems occasionally arise. Skilled preceptors often can turn difficulties around, or at least will take appropriate steps to resolve issues. Generally, this difficulty is related to student performance, but occasionally the issue is one of student dissatisfaction or poor communication, perhaps from lack of a good match between the student learning style and preceptor style or characteristics of the clinic. A "difficult student" may be frustrated, anxious, bored, overwhelmed, unprepared, distracted, ill, or otherwise having some difficulties.

Preceptors, faculty members, and students all need to be involved with resolution of student performance problems in the clinical setting. The preceptor's first resource is a close working relationship with the program faculty, and preceptors should not hesitate to ask for a "diagnostic visit" by program faculty. Some preceptors, especially inexperienced preceptors, are tempted to wait, sometimes for extended periods, thinking a difficult situation will "get better."

Communication with faculty is enhanced by a comprehensive assessment of factors that seem to contribute to the student's lack of performance. However, even if preceptors are not able to pinpoint specific factors, they should not hesitate to send up a "red flag" to program faculty. Serious problems should be addressed that very day with a call to faculty. Notes should be made regarding the situation of concern with dates and specifics, so that the faculty can be as well informed as possible when contacted.

Even when a potential problem seems to be emerging, the preceptor should maintain quality teaching. Opportunities for learning and application of knowledge should be provided. Continue to give the student specific rather than general feedback, share information rather than give advice, and, above all, keep communication open (Benzie, 1998). A key concept to keep in mind is that focusing on behaviors that can be changed rather than personality traits is the best strategy.

Diagnosing the Learning and Performance Issues

The diagnosis of clinical learning problems needs to include data about the setting and specific cases, the student's behavior, preceptor efforts and responses by the student, and the student's perceptions of the situation, all in light of course expectations. Data should include both the student's strengths and deficits. The preceptor should expect that the student (a) is prepared each day, (b) demonstrates history-taking skills appropriate for the situations at hand, (c) demonstrates critical thinking in data collection, (d) uses good physical examination skills to gather appropriate additional data, (e) demonstrates health promotion knowledge and management skills, and (f) uses knowledge of acute illness management to correctly make diagnoses and identify treatment options at a level appropriate to the course and curriculum. A student should also be able to maintain a reasonably organized approach to patient care and use of learning opportunities. Communication with staff, preceptor, and patients should be clear, organized, and appropriate. This also applies to written documentation and oral presentations of cases. Usually these elements will be consistent with clinical course objectives for NP courses. Examples of problems the preceptor may see include inability to take initiative

BOX 2. Indicators that the student is learning in the clinical setting

Behaviors that indicate the student is "getting it"

- Presents thorough, focused history and physical
- Consistently articulates sound decision making
- Develops and implements reasonable plan
- Connects with patient interpersonally in caring manner
- Is organized, independent, time-efficient
- Is self-confident but knows limits; asks for help
- Has holistic view of care; includes health promotion and disease prevention
- Provides concise charting and oral presentations

"Red flag" behaviors

- Is hesitant, anxious, defensive, not collegial
- Has uneasy rapport with patient and misses cues
- Presents less focused history and physical with excessive incomplete data
- Performs physical examination poorly, inconsistently
- Is unable to explain reasoning for diagnosis
- Is unable to prioritize patient problems
- Is unable to create plans independently
- Misses health education and disease prevention opportunities in plan
- Is unsure of tests to order
- Is unable to provide clear charting and presentations

Adapted from Ahern-Lehman, 2000.

and be responsible for parts of visits; inability to transfer knowledge from one situation to another; problems with communication with preceptor, staff, and patients; and failure to improve to the next learner developmental stage.

The preceptor and faculty need data to determine if the issue is related to a poor match between preceptor, setting, and student. For example, does the preceptor use a teaching style such as "sink or swim" that generates anxiety in this particular student sufficient to severely reduce performance? Or, is the setting too hectic, limited in space, unexpectedly busy, or providing inappropriate patients? (Benzie, 1998). Faculty and preceptor will need to discuss whether adequate adaptations can be made to achieve a fit for the student.

The level of performance should be specified through course objectives and an understanding of the course placement in the curriculum (e.g., a last-term course should have expectations approaching the new graduate's level of functioning). Preceptors may find it useful to document the behaviors identified by Ahern-Lehman (2000) as exemplars that students "get it" or behaviors that are "red flags" (see Box 2). Faculty absolutely need these data.

As a part of the student assessment, the faculty needs to determine if there are other issues from the student's perspective, including competing demands. The preceptor can provide helpful input to faculty from information provided by the student. Faculty will need to decide if the student has competing life crises and whether the student can realistically put the necessary effort toward clinical learning to meet course objectives. It is important that the preceptor not confuse the preceptor role with that of counselor. If assessment reveals mental health problems, faculty will refer the student to appropriate mental health services. In any case, even if the student is under unusual stress or going through a difficult time, the student is disadvantaged if preceptors and faculty do not have clear expectations for acceptable performance. Additionally, having an impaired student in the clinical setting can be extremely frustrating or even dangerous.

Additional Diagnostic Activities

If the preceptor's primary site is not optimal for evaluation of the student having trouble, several options may exist. Many programs have senior preceptor or faculty practice sites to use to diagnose student performance. In addition, some program faculty use laboratory simulations for diagnostic assessment. A simulation is conducted in a less intense environment and is accompanied by extensive analysis and debriefing, which can be helpful in assisting struggling students.

Implementing a Corrective Plan

If a "match" or "fit" problem is ruled out and a student problem is identified, a corrective plan needs to be developed by the preceptor/faculty team, a time frame set for corrective action, and an evaluation plan developed to determine if change has occurred. The plan

TABLE 3. Examples of interventions for problematic performance

Problematic performance examples	Interventions
Unorganized or incompetent history	If the student is not competent, determine if she or he has an organizational framework for history; if the student lacks a useful framework, re-orient to presentation basics (Coralli, 1989)
Lacks effective presentation skills	Encourage timing of verbal presentations and convey the expectation of extensive practice outside the clinical setting; effective strategies include rehearsal and use of a tape recorder; faculty may select and evaluate select taped presentations
Difficulty applying concepts covered in educational program	Give student responsibility to be prepared for one system (or specific problem) and a specific well-client visit for each clinical experience; ask student to outline the priority concerns, assessments, and decision points in a concise, articulate, and clinical relevant presentation in less than 4 minutes
Persistent difficulty "grasping" organization of problem-oriented chart and generating charting with logical flow	Refer to Office for Students with Disabilities for evaluation of possible learning disability

must involve preceptor, student, and faculty. Faculty need to determine if the student will drop out, move to a new site, or stay in the environment. If the student is to stay at the site, a specific plan to improve areas of concern must be developed. The plan may include more closely supervised time in faculty practice site, time observing role models, or extension of time in clinical setting (depending on school policies). The student must to be willing to make the commitment and effort to address the areas of identified concern. Finally, time for follow-up evaluation and criteria that all agree to must be set (Table 3).

Evaluation

While implementing a corrective plan, the preceptor needs to reassess the student at each clinical experience, determine if the student is making progress in the identified areas with the intensified input, and document each visit with short but specific descriptors about specified skills and progress or lack of it. The preceptor should let the student know where progress has been made as well as areas that need continued work, and must continue to use faculty as collaborators.

When the diagnosis is specific and interventions are aimed at the particular needs of the student, the most common outcome is improved performance. If improvement occurs and is satisfactory, faculty will need to determine what strategies need to continue for improvement in the next clinical. However, if performance continues to be unacceptable with outcomes not demonstrated in the time frame agreed upon, a recommendation for withdrawal from the clinical rotation or the program may be appropriate. Skillful academic counseling can often achieve this outcome in a way that provides the student with other career options. Faculty greatly appreciate preceptors for sensitive and useful assistance with diagnosis of failures of the student's performance to match the expectations of NP course and, ultimately, the NP role.

Learning Disabilities

It is not unusual for the demands of graduate education to uncover a learning disability that the student has been able to compensate for in previous education or professional practice. If the assessment process leads the preceptor and faculty to suspect a learning disability, referral to the university's Office for Students with Disabilities is recommended. Professionals can assess the student and, if necessary, refer the student for more in-depth assistance to identify the accommodations needed for the student's success. In addition, the Office for Students with Disabilities can provide counseling, coaching on effective strategies for learning, and advocacy for needed accommodations. Generally, if the student has a documented learning disability, accommodations are mandated by law. A student's or faculty's belief that a learning disability exists is not sufficient for accommodation. Documentation of a learning disability by a professional in this field is crucial for the student to have any "legal" right for accommodations. Preceptors who suspect a learning disability need to convey that information to faculty who, in turn, will work closely with appropriate academic units.

CONCLUSION

In conclusion, with appropriate expectations and some strategies for basic teaching with adaptations for special student and clinic needs, most practicing NPs can function as excellent preceptors. Preceptors are urgently needed to prepare the next generation of clinicians and to provide the access to patients so important to clinical learning. In turn, preceptors obtain satisfaction from meeting a professional obligation.

The great majority usually find teaching enjoyable, and they learn from the students. There is no "secret recipe" for successful precepting in a busy environment except the following: find the appropriate place, provide adequate light, nurture, protect and give time to grow! Being a preceptor is a rewarding activity. If the NP role is to continue, the best and brightest clinicians need to be involved with education of their future peers, and they will find the preceptor role enriching!

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Preceptor Toolkit

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Why Be A Preceptor

- Part of professional role being a teacher/evaluator is part of what we do as NPs (Ulrich, 2011)
- Satisfaction of "giving back" (Lyon and Peach, 2001)
- Being a role model and socialization expert- Students need to learn how to function in the "real world" and learn from our practices (both positive and negative) (Ulrich, 2011)
- Protecting both the patient and the student - patients are kept safe as the student learns in a safe environment (Ulrich, 2011)
- Preceptorships are essential for NP students to learn their craft (Burns, et al, 2006, Barker and Pittman 2010).
- Students keep us "on our toes" (Suzewits,2002)
- Enhances quality of practice

Qualities that make Super Preceptors

- Personality Characteristics:
  - Empathetic
  - Warm
  - Respectful
  - Sense of Humor
  - Flexible
  - Fair
  - Dependable
  - Consistent

Professional Characteristics

- Willing to work with a student who is a neophyte as well as a more advanced student
- Supportive of the student's educational program
- CURRENT IN KNOWLEDGE AND SKILLS
- Models appropriate behaviors and attitudes
- Willing to give constructive feedback
- Supports student growth

Concept of Positive Precepting (Murphy, 2008)

- Preparation-
  - What are the objectives for the student's learning experience?
  - What are the student's skills?
  - What is the student's schedule does it match mine?
  - Has the faculty member communicated expectations to you?

Concepts of Positive Precepting (cont'd)

- What experience is most appropriate for the student?
- Help the student talk out loud through the decision so you can hear their reasoning
- What are the expectations for student evaluation?
- What are the expectations for faculty visitation?

Expectations From the Program

- Clear expectations for the student's experience
- A syllabus for the course
- Clear communication pathways to faculty
- Recognition of your time and expertise
- Responsiveness to your concerns about the student
- Good record keeping of your efforts for recertification documentation

Expectations of Yourself as Preceptor

- Decide how much time and energy you are willing to commit and communicate this clearly to the faculty
- Verbalize your expectations of support from the faculty
- Remember that no preceptor is perfect- there may be times when you fail to connect with the student
- Forgive yourself- it's a learning experience for everyone!

Patient Expectations

- The patient should be informed that a student wishes to participate in the visit
- The patient must agree that a student may participate in the visit
- The patient should know that the visit might take additional time because they will be seen by the provider as well
- Often the patient is impressed that the provider has been selected to teach

Assessing Barriers to Precepting

- Space in the practice for exam rooms
- Space in the practice for talking with the student privately
- Space for the student to be when not seeing patients
- Melding the time it takes to precept into the productive schedule

Not Enough Time to Precept?

- Recent study in rural practice indicated that parallel precepting strategy was 12 minutes 24 seconds per visit and a "regular" consultation (without precepting) was 13 minutes 27 seconds. (Walters, Worley, Prideaux, Lange, 2008).
- Experienced preceptors take less time per visit with comparable outcomes (Baritt, 1997, Vinson, 1997).
- The take-away is that the more you do it, the better it gets from a time perspective

Barriers to Precepting (Time to Do It)

- Not much actual research with Nurse Practitioners precepting, but studies with medical students demonstrate feasibility of precepting and remaining productive (Amelia et al. 2001).
- Precepting takes additional energy even when it doesn't take much more time

Strategies for Working With Students

Flexibility The Key Ingredient

- Practice volume
- Temporary practice stresses-leaves, new providers, moves
- Demands of the program-time in class, number of hours, other assignments.

Wave Scheduling

- Wave scheduling-2 or 3 patients scheduled at the same time followed by a catch up break. The student sees one while you see the other/s. At some time, you see the student's patient as well.

  9:00 2 patients (each see one)

  9:20 catch up break for precepting, wrapping up visits

  9:40 2 patients

  10:00 catch up break (and so on….)

Built In Scheduling

- For example, one appointment time blocked in the schedule in mid morning, two blocked at different times in afternoon.
- Allows you to catch up for time you spent precepting and stay on schedule.
- Could potentially decrease productivity/reimbursement if your salary is productivity dependent.
- Need support from the practice for precepting to have this kind of flexibility

Sharing the Load

- Sharing a student between 2 or more preceptors lightens the responsibility, reduces the drag to productivity for any one person.
- Allows student to compare and contrast practice styles.
- May allow student to see different populations of patients

Student Thinking time

- Student sees patient, comes out, reports H and P to preceptor.
- Preceptor goes to see patient.
- While preceptor is seeing patient, student develops plan.
- Student reports plan to preceptor. Modifications are made as needed.
- Student or student and preceptor return to room to communicate plan to patient.

(personal communication, Kaye Lee, FNP, 2010)

Focused Half Day

- Student spends time before and after their patient arrives studying the chart, looking up material related to the focus of the day and the care of the patient.
- The schedule is the "table of contents" for the day's educational experience.
- You concentrate on seeing the rest of the patients and confine your teaching on that day to one issue.

  (Taylor, Lipsky, Bauer, 1998)

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Best Use of Focused Half Day

- Beginning student or students first days in a new setting-less overwhelming
- Especially busy days when the preceptor needs to see most of the patient at a more rapid pace.
- Students find that the preparation makes them more efficient and confident in the patient encounter. (Taylor, 1998)

Specific Skill Building

- The student spends the day observing you as you see patients, etc.
- You give the student an assignment during the day to observe how you do a particular aspect of the visit and reflect with you at the end of the day.
- Assignment can be opportunity to teach a student one way to do a particular skill or what to include in a particular type of visit.

When to Use Specific Skill Building

- Can help a struggling student see again and again how to do something and what variations you introduce with different patients.
- Can help you give the student a useful experience on a day when you don't have time for a lot of teaching.
- *Absolutely not appropriate for a student's entire clinical experience*.

Principles for Precepting Success

- Different learners, different levels of experience, different techniques
- Often we precept the way we were precepted
- Remember what helped you the most to learn.
- The larger our repertoire of clinical teaching techniques, the more likely we are to help students be successful.

Some Techniques To Help The Process of Precepting

- Case discussions
- Seeking appropriate patients for practice
- Direct questioning
- Think Aloud
- Assigning directed readings
- Coaching and “cheerleading”
- Observation

Micro Skills for Precepting

- An "Oldie but Goodie" for getting students to think about their encounters:
  - Get a commitment-*What do you think is going on?*
  - Probe for supporting evidence-*What led you to that conclusion?*
  - Teach general rules-*Many times when…*
  - Reinforce what was right-"*You did an excellent job of…*"
  - Correct mistakes-*Next time this happens, try this*

  (Neher, Gordon, Meyer, Stevens, 1992)

Advantages of the Micro-Skills

- Helps you see student's critical thinking process and ability to move from collecting data to planning care.
- Preceptor chooses one or more general rules to communicate from each encounter. Student doesn't have to intuit the general rules from the experience.
- Provides for immediate feedback about what was good and what needs correcting

Technologies and Precepting

- Using video cameras to observe student interactions with patients
- Need to be sure that all consents have been signed
- Watch and listen to the student doing a visit from outside the room.
- Student and patient have the primary interaction without you changing the dynamic between them, but you know everything that happened.
- Student has to do own improvising, problem solving because you aren't in the room to intervene. Patient has to focus on the student as provider.

Video Precepting

- Exams are only taped if appropriate.
- Not available in all settings.
- Can help you give more specific feedback to the student, especially if you watch the tape together later.
- Student can watch self and critique own interaction with the patient for discussion with you.

Evaluation of Students

- Often a stressful event
- It's not "ratting out" the student
- Should be constructive and based on skill development
- Should be consistent for student's level
- Should be respectful-focus on actions and preparation not personality
- Can be day to day feedback or interval evaluation

Principles of Evaluation

- Specific rather than general
- Timely
- Include student's assessment of personal growth
- Should be positive as well as negative
- Must be honest
- Include assignments for further study or improvement
- Should include communication to the faculty
- Expect cultural sensitivity

Dealing With Difficult Students

- Early communication of problems to both student and faculty
- Trust your judgment- you're the expert
- A failing student will often have limited insight or lack of personal awareness
- Remember the conversation is about the Student's learning, not your expertise
- Identify poor professional behavior or boundary breeches early and communicate expectations for change

Dealing With Difficult Students

- Patient safety is a primary concern
- If you don't think the student is safe, let the faculty know immediately
- Bring the faculty into the conversation early
- Consider having the student generate learning contract or daily objectives for improvement
- Expect professional behaviors and professional dress- don't hesitate to let the student know your expectations at the outset of the experience

Dealing With the Difficult Student

- DOCUMENT, DOCMENT, DOCUMENT
- Focus on behaviors rather than personality
- Faculty should visit and observe interactions
- Faculty should be supportive of your evaluation
- Suggest strategies for reassignment if necessary

Precepting Rewards

- Some programs pay stipends, most don't
- Many programs will offer adjunct faculty appointment (good for your CV and often include library privileges)
- Precepting keeps you sharp and current
- It often enhances your professional reputation
- There is satisfaction in doing the "right thing"
- It assures continuing excellence in the profession

Supervising, Teaching and Evaluating Fourth Year Medical Students

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Integrating a Medical Student into your busy practice—Key Points

- Orientation
- Expectations
- Autonomy
- Feedback

Above all, have fun!

5 Steps to Integration

- Orient the student to your practice
- Encourage patient acceptance of the student and your role as a teacher
- Adapt your schedule
- Keep the flow going
- Find time to teach

If you are working harder than the student, there is a problem

Orienting the Learner

- Develop a checklist
- Include your staff
- Delegate responsibility to staff
- Review student information, or have student provide it (clerkships completed, interests, goals)
- Assign the student tasks to complete
- Schedule orientation when it is most achievable.

Patient Acceptance

- **Review your schedule ahead of time**
  - Eliminate inappropriate patients
  - Select pts with interesting physical findings
  - Select pts who need a detailed or repeated exam
  - Select pts who need additional/detailed histories
- **Alert patient before encounter begins (front office/ nurse) that a student may be involved in their care**
  - Written/posted notice in waiting room & check in
  - Verbal information

Patient Acceptance

- Use positive language
  - NOT "You don't want to see a student today do you?
  - "How would you like to be a teacher today"
  - "Dr. Smith's medical student will be seeing you first to gather some history"
- Recognize and respect that not all pts want to be involved with teaching
- Consider having patients evaluate students
  - Friendliness, knowledge, interest in pt, listening
- Thank patients for their role in teaching

What 4th year students want: AUTONOMY

- Fourth year students are most intolerant of lack of autonomy.

"Shadowing" while appropriate for orienting and in certain other situations should never be the norm.

Scheduling

- **Number of pts**
  - Block out one or two appts for teaching/catch up time
- **Length of day**
  - Consider regular meeting schedules
  - Start early, order in lunch
- **Different kinds of appointments**
  - More walk in/Urgent care slots
  - Fewer full physicals
  - Out of office visits (home, NH visits)

Scheduling Alternatives

- "That's an interesting question. Why don't you look it up"
- Have the student spend time with your office staff (billing, front office, lab, nursing)
- Time with community agencies
- Time with a partner
- Time with a colleague (radiology, pathology, anesthesiology)

Scheduling Alternatives

Ask the student to:

- Accompany you to meetings or events
- Make follow up phone calls to patients or colleagues
- Do some legwork (get old records, schedule a referral)
- Develop patient education materials
- Accompany a patient (radiology)

Keep the Flow Going

- The student doesn't need to see every patient
- The student doesn't need to see every patient independently (some observation is ok)
- The student doesn't need to do everything on every patient they see
- Give the student time parameters "you have 5 minutes to take a detailed family history"

Keep the Flow Going

- Use focused teaching techniques such as THE ONE MINUTE PRECEPTOR
  - **Get a commitment from the learner—What do you think?**
  - **Probe for supportive evidence—Why?**
  - **Reinforce what was correct**
  - **Guidance about errors and omissions**
  - **Teach a general principle**

What to do when you're way behind?

- Slow learner:
  - Set time limits
  - Patient number limits
  - Give student time to prepare ahead (read the chart, look things up)
  - Go in and get them when you are ready
  - Take away their pen and paper (or limit the size of the paper)

What to do when you're way behind?

- Badly scheduled day:
  - Choose patients for student to see carefully
  - Give the student fewer, but more in depth tasks
  - Give the student alternate tasks to do, especially if they will help you get back on track

Finding Time to Teach

- Use THE ONE MINUTE PRECEPTOR
- Focus on one or two key points per patient
- Have student keep a small notebook of things to look up and discuss when there is a moment.
- Keep a folder or notebook of resources on the common topics that come up in your practice
- Encourage students to read the reference materials we have provided

Finding Time to Teach

- Remember that everything you do and say models how to be a physician. You don't have to be in "download mode" to teach.
- Use "learning issues" to guide students to do more self-directed learning, and report back
- Allow students to teach you

Feedback versus Evaluation

Feedback:	Evaluation:
- Timely	- Scheduled
- Informal	- Formal
- Formative	- Summative
- Specific	- Global
- Improvement	- Grading

How will you evaluate students?

- Did the student achieve the objectives?
- Will you remember this student in 5 years?
- Does this student stand out in one or more aspects of patient care?
- Did the student progress beyond their initial abilities

Our Expectations

- Orientation for student
- Ongoing formative feedback (frequent)
- Mid-rotation feedback session (2-3 weeks)
- Professionalism evaluation
- Prompt completion of paperwork

O-RIME Method

- Observer
- Reporter = Satisfactory
- Interpreter = Near Honors
- Manager = Honors
- Educator

Observer

A student in pre-reporter status, not meaningfully contributing to patient care activities. First- and second-year medical students largely are observers.

Reporter

- Student can accurately gather and clearly communicate the clinical facts about a patient. Mastery of this step requires the basic skills to obtain a history and do a physical examination and the basic knowledge of what to look for. The student "reports" the facts, such as, "the pt has had 3 days of increasing shortness of breath and fatigue", "the heart rate is 100", "the liver is 3 cm below the costal margin", "the sodium is 140." This descriptor emphasizes day-to-day reliability – for instance, being on time, or following up on a patient's progress. The student at this stage has a sense of responsibility and is achieving consistency in bedside skills in interpersonal relationships with patients. Reporter is minimum passing criterion in the third-year medical student clerkship. An OHSU student consistently at the level of "reporter" would receive a grade of "Satisfactory."

Interpreter

- Making a transition from "reporter" to "interpreter" is an essential and often difficult step in the professional growth of a student. An interpreter can report the facts accurately, and also can "interpret" these facts by thinking critically about the clinical data and formulating a differential diagnosis without prodding. Students at this stage can also advocate or refute diagnostic hypotheses. An interpreter might say, "2 month old male with unrepaired VSD now with a 2 day history of shortness of breath and poor feeding, and an exam significant for respiratory rate of 40, diffuse pulmonary crackles and liver down 3 cm below the costal margin, CXR remarkable for cardiomegaly and diffuse bilateral pulmonary opacification; therefore the pt most likely has congestive heart failure with fluid overload." An OHSU student who is consistently at the level of "interpreter" would receive a grade of "Near Honors."

Manager

- A student at the "manager" level can not only report and interpret the clinical data, he/she has the knowledge, confidence and judgment to decide on a course of treatment. This level requires higher-level interpersonal skills and involvement in patient care. A manager might say, "2 month old male with unrepaired VSD now with a 2 day history of shortness of breath and poor feeding, and an exam significant for respiratory rate of 40, diffuse pulmonary crackles and liver down 3 cm below the costal margin, CXR remarkable for cardiomegaly and diffuse bilateral pulmonary opacification; therefore the pt most likely has congestive heart failure with fluid overload. I propose we give lasix 1 mg/kg IV x 1 now." An OHSU student who is consistently functioning at the level of "manager" would receive the grade of "Honors."

Educator

- To be an educator, the trainee must be able to go beyond the basics of reporting, interpreting and managing the patient's clinical care. An "educator" is a self-directed learner, someone who defines questions to research and searches the literature for evidence on which clinical practice can be based. An "educator" then shares this information with others. This is a senior resident- or attending-level skill. However, students and residents at all levels should strive to be educators.

Potential Pitfalls in Evaluation

- Halo effect
- Insufficient evidence
- "You never told me that"
- "But I NEED honors"
- "Uh-Oh"—should they pass?
- "Lake Wobegon" effect

The "Halo Effect"

- One outstanding (often personal) characteristic that is not really related to what they are being evaluated on
  - Friendly, nice, outgoing, and well liked but clinically mediocre
  - Quiet, reserved or introspective student but clinically excellent
  - Shares a common interest at which they excel

Insufficient Evidence

- At the end of the rotation you have a sense that student performance was in some way inadequate but can't recall enough detail to provide specifics.
  - Frequent formative feedback, develop a system for recording and providing
  - BE SPECIFIC in daily feedback

"You never told me that"

- The first time a student hears about not meeting your standards should not be when they get their grade
- No surprises/ No assumptions
- If you expect the student to read nightly, tell them so. If you want them to pre-round daily, tell them so.

"But I NEED HONORS"

- Students should be evaluated on their current performance, not on their future plans
- Did they achieve the objectives of your course?
- Attitude/skills/knowledge in your area may be different than in their future area of expertise

UH-OH...Should this student pass?

- Contact your course director or the SOM Dean's office as soon as you suspect a problem
- Use the professionalism form
- Document as many specifics as possible
- Don't be afraid to bring an issue up—
  - It may be a non-issue, in which case it won't hurt the student
  - It may be an issue which we can then help the student address

The Lake Wobegon Effect

- Yes, all our students are above average (compared to the general population) but:
  - They are medical students, they have redistributed into a new normal distribution
  - Evaluation is a sometimes painful but necessary activity for their professional growth
  - Not all students are HONORS at all things. Overuse of honors diminishes its value
  - Near Honors or Satisfactory, when justified, is a perfectly fine grade and will not harm them.

Remember...

- Relax
- Enjoy
- Reflect
- Respect